Authorization for Release of Information

Child's Name: ____ D.O.B.:___________

Address: ____

City: ________________________________ State: ____________ Zip: _____________

Phone/Fax: ____

I hereby authorize and request Myers Park Pediatric Psychology/Michele Mannering, Ph.D. to:

_____ **Release information from my child's evaluation/treatment to the following person/facility:**

Name: ____
Address: ____
City: ________________________________ State: ____________ Zip: _____________
Phone/Fax: ____

_____ **Obtain information from the following clinician or person regarding my child:**

Name: ____
Address: ____
City: ________________________________ State: ____________ Zip: _____________
Phone/Fax: ____

Specify information to be released:
____ Neuropsychological or Education Evaluation Report
____ Educational Therapy Progress Information
____ Psychiatric/Psychological Treatment Information
____ Other: ______________________________________

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Signature of Parent/Guardian Date of Authorization