AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name_____ **Date of Birth**_____

I authorize the following parties to communicate with each other and exchange information regarding the above-referenced individual for the purposes of assessment, treatment, and/or educational planning:

_____ AND Janice C. C. Lepore, Psy.D. and Associates, LLC
Name of person/organization
1400 Front Avenue
Suite 204
Lutherville, MD 21094

_____
Street Address

Phone: (443) 912-1230
Fax: (888) 972-8138

_____
City State Zip Code

_____
Phone

The following information may be shared between the above-referenced parties:

___ Psychological Evaluations
___ Psychiatric Evaluations
___ Educational/Academic Evaluations
___ Educational/Academic Records
___ Teacher's Report
___ Verbal Communications
___ Psychological/Psychiatric Summary Notes
___ Other

I understand that this consent is valid for 12 months; however, I may revoke this authorization in writing at any time, except to the extent that action has already been taken. I understand that I may receive a copy of this form after I sign it and that I may inspect and request a copy of the information I am authorizing for disclosure. Information received may not be redisclosed without authorization.

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Witness Date