LORI RAPPAPORT, PH.D.

1265 High Bluff Dr. Suite 202 * San Diego, CA 92130
Telephone: (858) 481-2188 * FAX (858) 792-5095

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize **Dr. Lori Rappaport** and/or:

_____ Physician/Pediatrician - Phone

_____ School Principal/Administrator - Phone

_____ Psychiatrist – Phone

_____ Other - Phone

_____ Teacher - Phone

_____ Other - Phone

to disclose information and/or records regarding:

_____ Name of patient

_____ Date of Birth

The following information may be disclosed:

_____All pertinent records/information reports
_____Psychological/Psychiatric treatment reports
_____Medical records
_____Educational/School records
_____Diagnostic impressions
_____Psychological testing reports
_____Hospital records
_____Family history
_____Laboratory tests
_____Other (describe)_____

Disclosure of records is required for the following purposes:

_____Psychological treatment
_____Educational Planning
_____Medical evaluation
_____Court Request
_____Other (describe)_____

This consent shall terminate as of _____
(date)

In addition, I hereby authorize Lori Rappaport, Ph.D. to provide information, both oral and/or written, upon request, to the above stated person or agency.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been already taken. If not earlier revoked, this consent shall terminate one year from date signed below.

Thank you,

_____ Patient's Signature

_____ Date

_____ Parent, Guardian or Authorized Representative of Patient

_____ Date

_____ Relationship-if signed by other than Patient