LORI RAPPAPORT, PH.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize **Dr. Lori Rappaport** and the following to disclose information and/or records regarding myself or:

(Name of patient)_____ (Date of Birth)_____

Physician/Pediatrician:_____ Phone/Email:_____

Psychiatrist:_____ Phone/Email:_____

Teacher:_____ Phone/Email:_____

Other:_____ Phone/Email:_____

Other:_____ Phone/Email:_____

Other:_____ Phone/Email:_____

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 _____Court Request _____Educational Planning
_____Medical evaluation _____ ADHD Evaluation _____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.

_____ _____
Patient's Signature Date

_____ _____
Parent, Guardian or Authorized Representative of Patient Date

_____
Relationship-if signed by other than Patient