LORI RAPPAPORT, PH.D.
12625 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 _____

_____

to release all information, including educational, psychological, and health data contained in your records in the course of education, diagnosis and/or treatment on

_____ _____
Name of patient Date of Birth

This information/records shall be released to:

Lori Rappaport, Ph.D.

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 Witness