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AUTHORIZATION FOR RELEASE OF INFORMATION

To(Name and Contact Information):

RE: _____

DOB: _____

SSN: _____

I _____ authorize Karen Schiess Wagner, Ph.D, P.C. to release to **and/or** furnish the following information from my records to the above named person, firm, physician, clinic, school, hospital, or social agency:

- _____ Intake Summary, Termination Summary
- _____ Psychological Assessment, Psychological Test Data
- _____ Treatment Status, Progress Summary
- _____ Physical Examination and/or other Medical Data
- _____ School Records, School Performance, School Testing
- _____ Other _____

I hereby release the above named party from any liability for information furnished pursuant to this authorization. This release remains valid for the duration of the treatment period, if not specifically invalidated earlier, of the above named patient and copies and/or faxes of this authorization will be considered as valid as the original.

The purpose of this disclosure is:

- _____ To complete evaluation and facilitate treatment
- _____ Referral to another agency/treatment center
- _____ Other _____

THIS CONSENT TO DISCLOSE INFORMATION FROM MY RECORD MAY BE REVOKED BY ME, IN WRITING, AT ANY TIME UNLESS THE INFORMATION HAS ALREADY BEEN RELEASED. THIS CONSENT REMAINS VALID FOR ONE YEAR FROM THE DATE OF MY SIGNING.

PROHIBITION OF REDISCLOSURE: THIS INFORMATION IS CONFIDENTIAL AND PROTECTED BY FEDERAL LAW 42 CFH PART 2 WHICH PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

_____ PATIENT SIGNATURE _____ WITNESS

_____ PARENT/GUARDIAN SIGNATURE _____ DATE