PERMISSION TO RELEASE AND OBTAIN INFORMATION

Client name _____ **DOB** _____ **Today's date**_____

My signature below indicates my permission for the following individual/organization to release information as requested.

This permission is valid for 1 year from today and can be revoked in writing at any time. I understand that raw testing data can be released only to other appropriately credentialed professionals trained in test administration and interpretation.

_____ _____ _____
Person/Entity Phone Fax

_____ _____
Relationship/title Email (URL if no email available)

I authorize the disclosure of the following (check all that apply) **TO** Shapiro BrainHealth Group:

- □ All records
- □ General education records
- □ Verbal Communication
- □ Forms/rating scales
- □ Treatment plans/progress notes
- □ Special education/504 records
- □ Raw testing data
- □ Mental health records
- □ Treatment summaries/Evaluations
- □ Appointment/scheduling information
- □ Anecdotal observations/correspondence

□ Other _____

The purpose of the requested use/disclosure to Shapiro BrainHealth Group is for (check all that apply):

- □ Evaluation
- □ Coordination of care
- □ Benefits/payment
- □ Clinical/educational planning
- □ Progress update
- □ Medico-legal consultation
- □ Workplace supports

□ Other _____

I authorize the disclosure of the following (check all that apply) **FROM** Shapiro BrainHealth Group:

- □ Appointment notes (which will include mental health information)
- □ Evaluation report (which will include mental health information)
- □ Intervention recommendations
- □ General clinical impressions
- □ Appointment/scheduling information

□ Other _____

The purpose of the requested use/disclosure from Shapiro BrainHealth Group is for (check all that apply):

- □ Evaluation
- □ Coordination of care
- □ Benefits/payment
- □ Clinical/educational planning
- □ Progress update
- □ Medico-legal consultation
- □ Workplace supports

□ Other _____

_____ _____
Your name (Parent/Guardian if under 18) Signature