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AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL/MEDICAL INFORMATION

I, _____

the parent or legal guardian of: _____

(**Date of Birth:** _____), hereby authorize the office of **William L. Buchanan, Ph.D., ABPP** to release, either in a written letter or report or of a verbal nature, the information specified below:

_____Counseling and psychotherapy information, including problems, diagnosis, treatment and recommendations
_____Psychological and/or Neuropsychological Evaluation
_____Other:_____

For the Purpose of:
_____Professional consultation and coordination of services
_____Other:_____

To:_____

_____

_____

_____

_____

_____
Signature

I also authorize the above-named party to release, either in a written letter or report or of a verbal nature, his/her findings and/or opinion or any other relevant information to **William L. Buchanan, Ph.D., ABPP**.

_____
Signature

_____
Date

PLEASE SIGN ***BOTH*** PLACES ABOVE

I understand I have no obligation whatsoever to disclose the information, and I understand that this consent is revocable except to the extent that the action has already been taken and that this consent will remain in effect until:

_____

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal and State of Georgia Law. Unless the records of your program are also subject to Federal Law, federal regulations prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

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