Lifespan Development Center
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Authorization to Release Information

Federal law requires your specific authorization for release to appropriate parties any information about your or your child's treatment for certain conditions. Please complete all information below.

I, _____, authorize Roland Rotz, PhD, Woodwyn Koons, PsyD and staff to exchange information with:

_____

_____

_____

Relating to (Client)_____ Date of Birth _____

The information is required for diagnostic assessment, treatment planning and coordination of services.

Type of information needed: □ Summary of treatment □ Psychological Evaluation

□ Other: _____

I know that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.)

_____ _____

Date *Printed name of client/ guardian*

_____

Signature of client/guardian

This consent is subject to revocation at any time and will expire automatically upon termination, within one year of signature date, or by the date specified: _____

Revised 8/21