Alison E. Pritchard, Ph.D. LLC
Comprehensive Assessment

502 Baltimore Avenue, Towson, Maryland 21204 Phone: (443)904-2488 Fax: (410)494-0274

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name____ **Date of Birth**______________________

I authorize the following parties to communicate with each other and exchange information regarding the above-referenced individual:

____ AND

Name of person/organization

____

Street Address

____

City State Zip Code

____

Phone

____

Fax

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Towson, MD 21204

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The following information may be shared between the above-referenced parties:

___ Psychological Evaluations

___ Psychiatric Evaluations

___ Educational/Academic Evaluations

___ Educational/Academic Records

___ Teacher's Report

___ Verbal Communications

___ Psychological/Psychiatric Summary Notes

___ Other

I understand that this consent is valid for 12 months; however, I may revoke this authorization in writing at any time, except to the extent that action has already been taken. I understand that I may receive a copy of this form after I sign it and that I may inspect and request a copy of the information I am authorizing for disclosure. This information may not be redisclosed without authorization.

____ __________________________

Signature of Client/Guardian Date

____ __________________________

Signature of Witness Date