MIDSTEP™ CENTERS for Child Development

AUTHORIZATION FOR RELEASE OF INFORMATION
Peggy E. Nadenichek, M.Ed.

_____ _____
Patient Name Date of Birth

_____
Name of Facility (e.g., school, medical office, agency, hospital, etc.)

I hereby authorize the above-named facility to (check):
- ☐ Release information to Ms. Nadenichek for assessment and treatment purposes.
- ☐ Exchange information with Ms. Nadenichek for assessment and treatment purposes.

Authorized information to be released includes (check all that apply):
- ☐ Professional Contact Letter
- ☐ Psychological Evaluation Reports
- ☐ Psychological Treatment Reports
- ☐ Verbal Information or Discussion
- ☐ School Academic Records
- ☐ School Behavioral Records
- ☐ Medical Records
- ☐ Other: _____

Contact Person*: _____

Title: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

*The name of the person whose attention this notice should be sent. Unless stated otherwise, permission is granted to any authorized representative of the facility named above. To restrict permission to this individual, initial here: _____

This authorization shall be valid for one year from the date below, unless otherwise stated in writing.

_____ _____ _____
Parent/Guardian Signature Relation to Patient Date

_____ _____ _____
Parent/Guardian Signature Relation to Patient Date

_____ _____
Patient Signature (if 14 years old or older) Date

_____ _____
Witness Date