AUTHORIZATION FOR RELEASE OF INFORMATION
Kristen Smith-Simon, Ph.D.

____ __________________________
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):
- o Release information to Dr. Smith-Simon for assessment and treatment purposes.
- o Exchange information with Dr. Smith-Simon for assessment and treatment purposes.

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