Cher L. King, Ph.D.
Licensed Psychologist

Child and Family
Evaluations and Therapy

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RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

Parent/Guardian Name (if patient is a minor): _____

Dr. King is authorized to release specified records containing personal and confidential health information regarding the above-named patient to the following person or agency:

_____
Name of Person/Agency

_____
Address

_____
Contact Person

The records shall be released for the purpose of facilitating the treatment or the educational services of the above patient. The release also permits Dr. King to reveal to the above person/agency that she is treating the patient should she communicate with the above person/agency to request their records.

Specific records to be released:

__X__ Psychological evaluation results
__X__ Developmental/medical/social/family history
__X__ Treatment Plan including progress information
_____ Other: _____
_____
_____

This authorization shall remain in effect for six (6) months from the date of signing or the date listed below, whichever is sooner. I understand I have the right to revoke this authorization by providing written notice to Dr. King. Revocation does not affect releases of records made prior to the revocation. Dr. King is not responsible for any further disclosures of the released information by the recipient.

_____ Date: _____
Signature of Patient or Parent/Guardian (if patient is a minor)

_____ Release expires: _____
Relationship (six months from date signed)

04/07