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BOARD CERTIFIED IN CLINICAL NEUROPSYCHOLOGY
AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY
AMERICAN ACADEMY OF CLINICAL NEUROPSYCHOLOGY
NATIONAL ACADEMY OF NEUROPSYCHOLOGY

Authorization to Release Information

I authorize the person named below to release information about me/ my child regarding psychological and medical evaluation and treatment to Dr. David O'Grady for the purpose of psychological evaluation and treatment. The information sought is:

_____
_____
_____

This authorization shall remain in force for six months from this date unless revoked by me in writing.

RELEASE RECORDS FROM:
Name of doctor/hospital/institution

_____

_____

_____

REGARDING PATIENT:

_____
Name of patient

_____
Medical Number

_____
Date of Birth

_____
Signature

_____
Date