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Authorization for Release of Information

Name of Client : _____

Social Security Number (last 4 numbers): _____

Date of Birth: _____

I, _____, authorize Laeli S. Wilson, Psy.D.,
and/or any member of her staff to _____ exchange with, _____ disclose to and/or
_____ obtain from:

Name of Individual and/or Organization

Address, Phone Number, Facsimile Number

the following information:

_____ Social History	_____ Discharge Summary
_____ Medical Records	_____ Legal Status/History
_____ School Records	_____ Diagnostic Evaluation
_____ Other (specify) _____	

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without written consent unless otherwise provided for in the laws and regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent will automatically expired at/on:

Date or condition upon which this consent will expire: Upon completion of service(s).

Signature of Client: _____ Date: _____

Signature of Client/ _____ Date: _____

Legal Guardian _____ Date: _____