

LORI RAPPAPORT, PH.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize **Dr. Lori Rappaport** and the following to disclose information and/or records regarding myself or:

(Name of patient) _____ (Date of Birth) _____

Physician/Pediatrician: _____ Phone/Email: _____

Psychiatrist: _____ Phone/Email: _____

Teacher: _____ Phone/Email: _____

Other: _____ Phone/Email: _____

Other: _____ Phone/Email: _____

Other: _____ Phone/Email: _____

The following information may be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> All pertinent records/information reports | <input type="checkbox"/> Psychological testing reports |
| <input type="checkbox"/> Psychological/Psychiatric treatment reports | <input type="checkbox"/> Hospital records |
| <input type="checkbox"/> Medical records | <input type="checkbox"/> Family history |
| <input type="checkbox"/> Educational/School records | <input type="checkbox"/> Laboratory tests |
| <input type="checkbox"/> Diagnostic impressions | <input type="checkbox"/> Other (describe) _____ |

Disclosure of records is required for the following purposes:

- | | | |
|--|--|---|
| <input type="checkbox"/> Psychological treatment | <input type="checkbox"/> Court Request | <input type="checkbox"/> Educational Planning |
| <input type="checkbox"/> Medical evaluation | <input type="checkbox"/> ADHD Evaluation | <input type="checkbox"/> Other (describe) _____ |

This consent shall terminate as of _____
(date)

In addition, I hereby authorize Lori Rappaport, Ph.D. to provide information, both oral and/or written, upon request, to the above stated person or agency.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been already taken. If not earlier revoked, this consent shall terminate one year from date signed below.

Patient's Signature

Date

Parent, Guardian or Authorized Representative of Patient

Date

Relationship-if signed by other than Patient