DRS. ROFFMAN, CAVANAGH
& ASSOCIATES

Nancy H. Roffman, Psy.D.
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RELEASE OF INFORMATION

_____ _____
Patient Name Patient Date of Birth

_____
Parent/Guardian Name

I hereby authorize Drs. Roffman, Cavanagh & Associates to communicate with one another regarding the minor patient for the purposes of therapeutic treatment, assessment, or educational planning. During these communications, we strive to protect patients' confidentiality during discussions and only share what is necessary to ensure that the best treatment practices are being followed. Any questions or concerns should be discussed with your treatment provider

I hereby authorize Drs. Roffman, Cavanagh & Associates to communicate with the following individuals or organizations to obtain information for the purposes of therapeutic treatment, assessment or educational planning.

Name of individual or organization and contact information:

_____

_____

I authorize that the following information may be shared:

_____ Psychological Evaluation Reports
_____ Psychiatric Evaluation Reports
_____ Medical or Hospital Records
_____ Educational/Academic Evaluations
_____ Educational/Academic Records
_____ Report of Teacher Observations
_____ Verbal Communications
_____ Psychological/Psychiatric Summary Notes

_____Other_____

I recognize that this authorization will expire after a one-year period or with written request of parents or patient of legal age.

I also understand that I have the right to revoke this consent in writing at any time as directed to Drs. Roffman, Cavanagh & Associates. However, my right to revoke this consent will not be effective to the extent that action has already been taken in accordance to this release of authorization.

I understand that the psychologist/social worker **will not send information about patients electronically or by Fax due to confidentiality issues. _____ (initial)**

I understand that I may receive a copy of this form after it has been signed and dated.

Upon giving this consent, recognize that I release the above parties from any legal liability for the release of this information.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date