CLARE AMES-KLEIN, PH.D.
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CONSENT/AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name or Child's Name:______________________________D.O.B.___________

Address:____

Telephone No: _____________________________E mail_______________________

I authorize and request that the following persons/agencies:

Release information in my clinical records **to** Clare Ames-Klein, Ph.D.______________
Obtain information in my clinical records **from** Clare Ames-Klein, Ph.D_____________

Individual's/Agency Name:____

Address: ____

Telephone Numbers:____

E-mail: ____

Information to be disclosed (check all that apply):

- ❑ General clinical impressions
- ❑ Evaluation results
- ❑ Evaluation report
- ❑ Progress notes
- ❑ Evaluation recommendations
- ❑ Other: ______________

I am authorized to provide consent for this release of information to Dr. Clare Ames-Klein. I understand that this authorization is voluntary and may be revoked in part or in whole at any time.

_____________________________ Name (printed)

_____________________________ Signature

Relationship to Client:____________________________Date:_________________