

RELEASE OF INFORMATION
Lisa Ahern, Ph.D., PLLC
CONFIDENTIAL

Client Name: _____ Birthdate: _____

I hereby authorize Dr. Lisa Ahern of Lisa Ahern, Ph.D., PLLC to:

- Release information to
- Obtain information from

The following persons/agencies:

Name of Persons/Agency: _____

Email Address(s): _____

Telephone/Fax Number: _____

For the purposes of (check all that apply):

- Psychological/educational evaluation
- Consultation and treatment planning
- Record review by a school or treatment professional
- Billing and Insurance concerns
- Other: _____

This information will include:

- All Records
- Identifying Information (name/DOB/grade) and status as a patient/student
- Reason for Request (Evaluation/Treatment)
- Behavioral Observations/Checklists
- School/Educational Records
- Therapy Notes/Treatment Plans
- Discharge Summary
- Psychological/Psychoeducational Testing Reports
- Billing/Insurance Information
- Other: _____

This authorization shall remain in effect for one year or until (date) _____

You have the right to revoke this authorization, in writing, at any time by sending written notification to the office address.

Client's Signature (if over age 18)

Date

Signature of Parent/Legal Guardian

Date