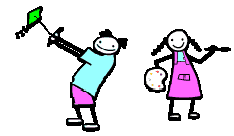


Center for Psychological and Educational Assessment

Comprehensive Evaluations for Children



Dana D. Weinstein, Ph.D. ♦ Melissa C. Lang, Ph.D., NCSP ♦ Robyn Racey-Wehr, M.S., CCC-SLP
♦ Autism Spectrum ♦ Learning Disabilities ♦ Attention Difficulties ♦ Speech & Language Assessment ♦ Occupational Therapy ♦

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of client or patient: _____

Date of Birth/Identification #: _____

I request and authorize: Dr. Dana Davis Weinstein
Dr. Melissa C. Lang

To obtain from or exchange with: _____
(Name of Person or Agency Holding Information)

the following information: _____

for the purpose(s) of: _____

All information I hereby authorize to be obtained from this person or agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for 90 days unless I specify an earlier expiration date here: _____. I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. However, such withdrawal may not be retroactive (that is, withdrawn consent will not apply to information transfer that has already taken place).

Signature of Client, Patient, or Responsible Party

Date

Signature of Witness

Date

IF PATIENT WITHDRAWS CONSENT

Signature of Patient that consent was withdrawn, if less than 90 days)

Date