54 South Avenue
Marietta, GA 30060

519 Memorial Drive, B-10
Atlanta, GA 30312

Center for Psychological and Educational Assessment

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
Dr. Adria Garrett
Dr. Jamie Miller
Dr. Lee Ann Scott

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 However, such withdrawal may not be retroactive (that is, withdrawn consent will not apply to information transfer that has already taken place).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Signature of Patient that consent was withdrawn, if less than 90 days) Date