SAN DIEGO ADHD CENTER FOR SUCCESS

1265 High Bluff Dr. Suite 201 * San Diego, CA 92130
Telephone: (858) 481-4988 * FAX (858) 792-5095

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________ hereby authorize **Dr. Lori Rappaport** and/or:

______________________________	______________________________
Physician/Pediatrician - Phone/Email	Other- Phone/Email
______________________________	______________________________
Psychiatrist – Phone/Email	Other - Phone/Email
______________________________	______________________________
Teacher - Phone/Email	Other - Phone/Email

to disclose information and/or records regarding:

__________________________	___________
Name of patient	Date of Birth

The following information may be disclosed:

_____All pertinent records/information reports
_____Psychological/Psychiatric treatment reports
_____Medical records
_____Educational/School records
_____Diagnostic impressions
_____Psychological testing reports
_____Hospital records
_____Family history
_____Laboratory tests
_____Other (describe)_____________________

Disclosure of records is required for the following purposes:

_____Psychological treatment
_____Educational Planning
_____Medical evaluation
_____Court Request
_____Other (describe)
_____ ADHD Evaluation

This consent shall terminate as of _________________
(date)

In addition, I hereby authorize Lori Rappaport, Ph.D. to provide information, both oral and/or written, upon request, to the above stated person or agency.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been already taken. If not earlier revoked, this consent shall terminate one year from date signed below.

Thank you,

____ ______ ___________
Patient's Signature Date

____ ___________
Parent, Guardian or Authorized Representative of Patient Date

____
Relationship-if signed by other than Patient