Behavioral Diagnostics & Treatment
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Release of Information Form

Student Name: _____ _____ Date of Birth:____/____/_____

I hereby authorize: ☐ Michael J. Fulop, Psy.D. ☐ Antonia Forster, Ph.D., ABPP ☐ Ana Cragnolino, PhD

To: ☐ obtain from ☐ disclose to ☐ exchange with:

School or Agency: _____ Specific Person(s): _____

Street Address: _____ City _____ State: ____ Zip: _____

Phone: ____-____-_____ Fax: ____-____-_____ Email: _____@_____

The following information *(Check all that apply):*

- ☐ Information re: Academic issues
- ☐ Information re: Behavioral issues
- ☐ Information re: Diagnostic information
- ☐ Health Information re: Diabetes Management
- ☐ Information re: Other Medical Issues
- ☐ Information re: Psychological Treatment
- ☐ Information re: Family Issues
- ☐ Information re: Relevant History
- ☐ Information re: Psychological Test Information, or Psychological Assessments
- ☐ Information re: Alcohol or Drug Abuse History
- ☐ School Reports, Standardized Testing Results Reports, Academic Grade Reports
- ☐ Individualized Education Plan or Section 504 Plan
- ☐ Transparency for Access to Student/Patient online portal [login details for Homework Coaching]
- ☐ Other _____
- ☐ All of the above

I _____ *(PERSON COMPLETING FORM, PLEASE INITIAL)* hereby give consent to this **Release of Information** *(all checked above)* including mental health records obtained in the course of diagnosis, education, And/or treatment with the above patient or student. I understand that such information cannot be released without my specific consent, except in a medical emergency, and is being released _____ (*INITIAL)* for the continuation of treatment, _____ *(INITIAL)* at the request of the patient, their parent, or legal guardian.

This authorization is valid for 1 year from the date below unless revoked in writing earlier. Once information has already been released, this authorization cannot be revoked for that released information, and when others have possession of the disclosed information, your BDTX provider cannot guarantee that the information will remain confidential.

Patient Name: _____ Date: ____/____/_____

Patient Signature *(If ≥ age 18):* _____ Date: ____/____/_____

Print Parent or Guardian Name: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian ☐ Other: _____

Parent or Guardian Signature: _____ Date: ____/____/_____