

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:** ___/___/___