Request/Authorization to Exchange Confidential Records and Information

I hereby authorize:

Person or facility:_____

Address:_____Phone: _____

_____

to exchange information from records about_____, born on_____,

with:

Dr. Michael S. Lax
NY Licensed Psychologist
(866) 237-9930
drlax@mdofficemail.com

1580 East 18th St
Brooklyn, NY 11230

3176 State Route 27, Suite 2B
Kendall Park, NJ 08824

for the following purpose(s):

- □ Further mental health evaluation, treatment, or care
- □ Treatment planning
- □ Other: _____

These records concern the time between_____and_____.

The information to be disclosed is marked by an X in the boxes below:

- □ Medical history and evaluations
- □ Mental health evaluations
- □ Developmental and/or social history
- □ Educational records
- □ Progress notes, and treatment or closing summary
- □ Other: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____
Signature of Client/Parent Date

_____
Print Name