THE ATLANTA PSYCHOLOGY GROUP
Comprehensive Evaluations for Children & Adolescents

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**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I authorize Dr. Corbin Feroleto, Dr. Jennifer Foster, Dr. Fontina Rashid, Dr. Jessica Conklin and Dr. Emily Bryant to

- Release a psychoeducational report to a specified person
- Discuss the findings of the report with a specified person
- Contact a specified person who can provide relevant information
- Conduct a school-based observation and interview of classroom teachers

for my child_____

to_____
_____

(name and school/organization and address and phone number)

This authorization shall remain in effect until_____
Please note that you have the right to revoke this authorization at any time by sending written notification to our office address. Your revocation will not be effective to the extent that we have already acted in reliance on the authorization or if this authorization was obtained as a condition of acquiring insurance coverage and the insurer has a legal right to contest a claim.
I understand that the confidential information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____
Signature of Patient, or if a minor, Parent Date

_____ _____
Signature of Witness Date