Neuropsychology and Educational Clinic
for Children and Adolescents
Karen P. Kelly, Ph.D.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Full Name) (Relationship to child)
hereby authorize the communication between parties noted below as well as the release of my child's health information to the Neuropsychology and Educational Clinic for Children and Adolescents.

_____ _____
(Child's Full Name) (Date of Birth)

between

Name: _____
Address: _____
City, State, Zip: _____

and

Neuropsychology and Educational Clinic for Children and Adolescents
Karen P. Kelly, Ph.D.
987 Old Eagle School Road, Suite 719
Wayne, PA 19087

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or medically sensitive information.

Purpose of disclosure: Neuropsychological Evaluation

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not redisclose my child's medical record to another party without further written consent. I will not hold Karen P. Kelly, Ph.D. liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Kelly for clarification of the information therein.

Date: _____ Signature: _____
(Legal Guardian or Legal Representative)

Date: _____ Witness: _____