Lauren Perlmutter, Executive Functioning Coach

Supervisor: Christopher Fulton, Ph.D., PSY 14741

Authorization to Release Information

Patient: ____

Address:____

I hereby authorize Lauren Perlmutter to disclose and/or receive from

____

(name) (phone #)

information pertaining to my (or my child's) psychological services rendered from:

_______ to _______.

Specific information requested includes: _____________________________________

____

This authorization is good until: _____________________________

This authorization allows Lauren Perlmutter to discuss information described above and can be canceled at any time in writing by the patient.

Signature: ____ Date: __________
(parent, if patient is a minor)

Lauren Perlmutter's signature: ___________________________________ Date: __________