



3500 Piedmont Road, NW Suite 740

Atlanta, GA 30305

(404)875-2050

Corbin Feroletto, Ph.D.

Jennifer Foster, Ph.D.

Emily Bryant, Ph.D.

Julie Cash, PsyD

Fontina Rashid, Ph.D.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize Drs. Corbin Feroletto, Jennifer Foster, Emily Bryant, Fontina Rashid, Julie Cash 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 the following individuals/entities: _____

(include 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