Helping Children & Families Grow Together
Kearney N. Visser, Ph.D. PSY23855

Authorization to Exchange Confidential Information

Name: _____DOB: _____

Name of legal guardian(s): _____

_____

I understand that the purpose of this release is to assist with my treatment by improving communication between professional service providers or agencies and the important individual(s) in my life. To further this goal, I authorize two-way communication between ***Dr. Kearney N. Visser*** and the below stated professional:

_____ _____
Name of person/Program Relationship

_____ _____Fax number
Phone number

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

❑ Treatment plan/summary ❑ Scheduled appointments
❑ Progress notes ❑ Compliance with treatment ❑ Psychological evaluation(s)/assessments ❑ Medications /allergies
❑ School information (report cards/teacher reports) ❑ Other:
_____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire ❑ one year from this date, ❑ upon my discharge or by the person specified above, or ❑ under these circumstances: _____.

_____ Printed name

_____Signature

_____
_____Signature of legal guardian/client Date

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