Kirk Neurobehavioral Health
Developmental Neuropsychology

Authorization to Request or Release Confidential Information

Client's Name _____

Date of Birth _____ Social Security Number _____

Name of Parent/Guardian or Previous Name _____

I hereby authorize (circle specific provider) John W. Kirk, Psy.D. , Jennifer Kirk, Psy.D., Cassie Green Psy.D., or Alicia Williams, Psy.D. to **request/release/exchange** information **from/to/with** the following individual, provider or institution. **(Please specify direction of information exchange.)**

_____
Individual, Provider or Institution

_____
Address

_____
Telephone Fax

Specific Information Requested: _____

_____

[Medical records, treatment/progress notes, psychiatric medical records, verbal consultation between providers, psychological testing, educational testing, educational plans, staffing reports, IQ tests and scores, school transcripts, college entrance exam scores, **complete school records including special education records**]

The purpose for the release of these records is evaluation and treatment planning. This authorization extends to the release of any drug and alcohol related information in the record. This authorization may be revoked by notifying Kirk Neurobehavioral Health in writing. A photocopy or facsimile transmission of this release shall be accepted as the original. Unless otherwise indicated here (expires _____) this authorization expires 24 months from the date signed.

Any information released by this office to another individual or entity shall not be forwarded without written authorization and further consent by the patient or guardian.

I understand that I have the right to receive a copy of this authorization upon my request.

Signature of Client
or Legal Representative: _____ Date: _____

Witness: _____ Date: _____

400 S. McCaslin Blvd., Suite 212 • Louisville, CO 80027
(303)915-0108 • Fax (720) 627-5843