April R. Holman, Ph.D.
Licensed Psychologist, PSY 10920
667 Lytton Avenue, Suite 5
Palo Alto, California 94301
(650) 323-6757

Authorization for Exchange of Confidential Information

Child's Full Name: _____ Date of Birth: _____

I, _____ give my permission for:
(Name of Parent or Guardian)

An exchange of information and records between Dr. Holman and [names & addresses below]:	A release of records from Dr. Holman to [names & addresses below]:	A release of records to Dr. Holman only from [names & addresses below]:

_____
Agency Name Address Phone/Fax

_____
Agency Name Address Phone/Fax

_____
Agency Name Address Phone/Fax

This release shall be limited to the following specific information:

❏ Diagnosis ❏ Legal status ❏ Pertinent summary of psychosocial and psychiatric history and treatments ❏ Medical information, including the results of medical tests or medications ❏ Results of psychological and vocational tests	❏ Educational assessments and behavioral reports, including school observations and educational testing ❏ On-site consultations/observations ❏ Billing information ❏ Other: _____ _____ _____

_____
(Parent/Guardian Signature) (Date)

_____
(Parent/Guardian Signature) (Date)

This authorization shall be valid for only _____ days or until this date: _____