Sven Schild, Ph.D.

Clinical Psychologist (Lic.#: PSY22339)

www.svenschild.com

Please sign the statement below giving your permission for me to communicate with the following individual, agency, or insurance company on your behalf:

_____

(name of individual, agency, company to be contacted)

_____

(address, city, state, zip of said individual, agency, company)

_____

(phone/fax)

I, _____, born on _____, hereby authorize
(name of patient) *(date of birth)*

_____ to disclose/obtain (circle one or both) the following
(name of doctor)

information from clinical records.

❑ Diagnosis and dates of treatment ❑ Summary of treatment

❑ Psychological evaluation/assessment ❑ Relevant treatment records

❑ Other _____

about me/my child, _____
(child's full name)

for the following purpose: _____

This authorization and request to disclose or obtain information from my records will expire after one (1) year from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

Patient Name/Guardian Name _____

Patient/Guardian Signature _____ Date _____

Relationship to patient:

❑ self ❑ guardian ❑ parent of a minor

❑ person legally authorized to act on the behalf of the patient.