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CONSENT for RELEASE of INFORMATION (ROI)

I authorize Dr. Onufrak to:

☐ Exchange information with: ☐ **ONLY** receive info from:

____ / ______________________________
(Name of professional) (title: teacher, psychiatrist, PCP, etc.)

Facility name: ____

Mailing address: ____

Phone #: __________________ Fax #: _______________ Email: _________________

pertaining to my child:

____ ______________________
(Name of child) (date of birth)

____________________________ ________________________ __________
(Signature of legal guardian) (relationship to child) (today's date)

____________________________ __________________________ ___________
(Signature of legal guardian) (relationship to child) (today's date)

regarding (check all that apply): ☐ psychological evaluation ☐ psychiatric records
☐ psychoeducational testing/reports ☐ academic functioning ☐ school behavior
☐ observation of child's functioning ☐ therapy recommendations ☐ medical information

This consent will remain in effect until: *(Please check one)* ☐ End of treatment
☐ End of school year ☐ 90 days (ending ________) ☐ Other: ___________________________

Note to Parent: This consent may be ended at any time by the child's guardian. Ending the consent will not cancel any action that has already taken place, but will prevent any future exchange of information.

Note to party receiving information: This information has been disclosed to you from confidential records which are protected by federal law, prohibiting any further disclosure of this information without the specific written consent of the person to whom it pertains (or that person's legal guardian), or as otherwise permitted by such regulations.