Tuckahoe
Child Psychology

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AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION FOR EXCHANGE OF INFORMATION BETWEEN DR. SANDRA H. HENDERSON AND THE AGENCIES LISTED BELOW:

I hereby authorize the mutual exchange/disclosure of information relative to myself/my child as initialed below between Dr. Sandra H. Henderson of Tuckahoe Child Psychology, PLLC and the agency/agencies listed below.

Patient's Name: _____ Date of Birth:_____

Name: _____ Name: _____
Agency: _____ Agency: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

Name: _____ Name: _____
Agency: _____Agency: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

Initials	Item(s) for Release:

_____ Verbal Exchange of Information
_____ Initial Evaluation Note
_____ Psychological Evaluation
_____ Social History
_____ Educational Evaluation and Records
_____Closing Summary
_____ _____

I hereby release the above individuals and agencies from all liability and all claims of any nature whatsoever pertaining to disclosure of information contained in my records. I understand that this original release or legible copy is VALID FOR ONE YEAR FROM THE DATE SIGNED unless revoked by me in writing at any time prior to the expiration date.

Parent/Guardian: _____ Date: _____
Relationship to child: _____
Child Signature: _____ Date: _____
Witness: _____ Date: _____

TWO witnesses required for verbal permission granted over the phone.
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.