FPI Attention Disorders Clinic, 94 Marshall Dr., Endicott, NY 13760
Phone: 607-785-0400 Fax: 607-785-0077

Consent for Release of Information

I/we the undersigned, give consent for Dr. Monastra and the FPI Attention Disorders Clinic to provide the following information to:

___ Physician's Name: ______________________________

___ School District: ______________________________

___ CSE Chairperson: ______________________________

___ Office for Students with Disabilities ______________________________

___ Other: ______________________________

_____ Psychological Evaluation/Test Report: Includes written presentation of

- Medical, developmental and social history
- Clinical observations during evaluation
- Test results
- Interpretation of test results, diagnosis and recommendations.

_____ Treatment Summary: Includes written description of

- Reasons treatment was requested
- Diagnosis
- Treatment plan
- Outcome of therapy and clinical status at time treatment was concluded

_____ Discussion of diagnostic or treatment issues: Includes professional conversations Regarding psychological evaluation or treatment as described above. However, no Written report is authorized.

_____ Billing Claims Submission: Includes verbal and written communication about diagnostic And treatment issues necessary for processing of insurance claims

_____ Other: ______________________________

I understand that such disclosure is bound by regulations governing the confidentiality of medical/psychological records and the release of this information to a party other than the one(s) designated above is prohibited without additional written authorization on my part. I also understand that I can cancel my permission to release information at any time before it is released. My consent to release this information will expire 90 days from this date if not acted upon prior to that time.

Patient: ______________________ Date of Birth ______________________

Parent (Guardian) Signature (for minors) ______________________ Date __________

Adult Patients Signature: ______________________ Date __________