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 _____

to provide the following information to _____

of the FPI Attention Disorders Clinic:

____ Medical records (including physician notes, laboratory and imaging results)

____ Psychological Evaluation/Test Report

____ Treatment Summary

____ Psychiatric Examination/Discharge Summary

____ School Transcripts/Academic Records

____ Written Teacher Reports

____ CSE Summary/ IEP/ 504 Accommodation Plans

____ Professional Conversations regarding diagnostic and/or treatment issues

____ Other: _____

I understand that disclosure of this information to anyone other than those listed above is prohibits. I also understand that I have the right to cancel my permission at any time before information is released. My consent to release information will expire 90 days from this date if not acted upon prior to that time.

Patient Name: _____ Date of Birth: _____

Parent (Guardian) Signature (if patient is a minor) _____

Adult Patient's Signature: _____ Date: _____