RELEASE OF INFORMATION
Lisa Senatore, Ph.D., PLLC
CONFIDENTIAL

Client Name: _____Birthdate: _____

I hereby authorize Dr. Lisa Senatore of Lisa Senatore, Ph.D., PLLC to:
☐ Release information to
☐ Obtain information from

The following persons/agencies:

Name of Persons/Agency: _____
Email Address(s): _____
Telephone/Fax Number: _____

For the purposes of (check all that apply):
☐ Psychological/educational evaluation
☐ Consultation and treatment planning
☐ Record review by a school or treatment professional
☐ Billing and Insurance concerns
☐ Other: _____

This information will include:

☐ All Records
☐ Identifying Information (name/DOB/grade) and status as a patient/student
☐ Reason for Request (Evaluation/Treatment)
☐ Behavioral Observations/Checklists
☐ School/Educational Records
☐ Therapy Notes/Treatment Plans
☐ Discharge Summary
☐ Psychological/Psychoeducational Testing Reports
☐ Billing/Insurance Information
☐ Other: _____

This authorization shall remain in effect for one year or until (date)_____

You have the right to revoke this authorization, in writing, at any time by sending written notification to the office address.

_____ _____
Client's Signature (if over age 18) Date

_____ _____
Signature of Parent/Legal Guardian Date