

**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