Powers Ferry Psychological Associates, L.L.C.

The Offices of:
Gerald S. Drose, Ph.D.
Dina M. Zeckhausen, Ph.D.
Steven Perlow, Ph.D.
David M. Schwartz, Ph.D., ABPdN
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Kimberly Smiley, Psy.D.
Jennifer Spring, Ph.D.

And the Offices of:
Martin Fleet, Ph.D.
Susan Berel, Ph.D.
Elaine Eassa, Ph.D.
Keith Helmken, LCSW
Jennifer Swales, Ph.D.
Rachel Scheinfield, Ph.D.
Brian Smith, Psy.D.
Katherine Higgins, Ph.D.

Release of Information

I hereby authorize _____

to: ☐ release ☐ receive ☐ exchange

any and all information concerning _____ (Name of Patient, DOB)

☐ to ☐ from ☐ with **David M. Schwartz, Ph.D., ABPdN**

I understand that such disclosure will be made for the following purposes:

☐ Neurosychological Evaluation ☐ Psychiatric Evaluation ☐ Child Custody/Visitation
☐ Diagnosis ☐ Social History ☐ Competency to stand trial
☐ Medical Treatment ☐ Treatment Progress ☐ Treatment Summary
☐ Academic Placement ☐ Other _____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and if not earlier revoked, it shall terminate 365 days from date of signature without revocation.

I understand that disclosures may not be subject to confidentiality if Dr. Schwartz becomes aware of any suicidal or homicidal thoughts or plans, or any form of abuse or neglect.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read or had read to me, the above information and understand the contents.

_____ I authorize this information to be faxed or emailed to the party indicated above and understand
Initial the limits of confidentiality which doing so creates.

Signature: _____ Date: _____

or

Signature: _____ Date: _____
(Parent, Guardian, or Legal Representative)