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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize Joanna T. Koulianos, Ph.D. and _____ (Individual name or Facility that currently has your/your child's records) at _____ (Address and/or Phone number) to discuss all **pertinent** confidential information pertaining to me/my child in conjunction with a psychological or neurocognitive evaluation which I/my child am undergoing.

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing Dr. Koulianos in writing and specifying the above noted individuals or facilities.

_____ _____

(Signature of Client / Guardian) **(Date)**