WINS*i*
WESTERN INSTITUTE FOR NEURODEVELOPMENTAL STUDIES AND INTERVENTIONS
2501 Walnut Street, Suite 102
Boulder, CO 80302
Telephone: (303) 442-4750 ⌘ Fax: (303) 443-4682

Kytja K.S. Voeller, M.D., Director
Jill Gitten Aloia, Ph.D., Associate Director, Neuropsychologist
Jean Riordan, Ph.D. CCC/SLP, Associate Director, L.D. Speech/Language Therapy Supervisor
Martha Everett, M.A. L.D. Specialist, School Liaison
Grant Chambers, B.A., Operations Manager
Karen Majesky, B.A., ASL Interpreter, Therapist
Karina Black, OTR, Occupational Therapist
Kristin Braymiller, B.A., Therapist
Joshua Morris, B.A. Recreational Therapist
Linda Hill-Blakley, B.A., Therapist
Kimberly Ward, B.A., Therapist
Kathryn Kaldor, M.A., Therapist
Claire Garrison, B.A. Therapist

AUTHORIZATION TO RELEASE AND SHARE INFORMATION

Patient's Name:_____
First Name MI Last Name Date of Birth

Kytja K.S. Voeller, M.D. and the staff of WINSi are hereby authorized to obtain information from, and share information with, the following professional or agency:

_____
Name

_____
Address City/State/Zip

This information may include:

- ☐ Psychiatric History, Including Diagnosis and Treatment
- ☐ Psychological/Neuropsychological Testing/Consultations
- ☐ Admission History, Physical, Discharge Summary, Operative Reports
- ☐ Physical Examination, Lab Studies, X-rays, EKG, EEG
- ☐ Drug/Alcohol History and Treatment
- ☐ Academic records and school behavioral reports
- ☐ Educational Evaluations
- ☐ Mother's obstetrical records and infant's neonatal records
- ☐ Speech/Language, Occupational Therapy Evaluations

This authorization to release/request information will expire one year from the date of signature and may be revoked at any time by giving written notice to Dr. Voeller. I understand that the material to be released may include information regarding Drug and Alcohol Abuse, Neurological or Psychiatric Conditions, and/or HIV/Auto Immune Deficiency Syndrome. If the information to be released pertains to the diagnosis and treatment of alcoholism or drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42, C.F.R., Part 2. Federal regulations prohibit the person receiving this information from making further disclosure of the information without specific written consent of the person to whom it pertains.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Signature of Witness Date