

WINSi

WESTERN INSTITUTE FOR NEURODEVELOPMENTAL STUDIES AND INTERVENTIONS
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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