Tina Schneider, Ph.D.

Request/Authorization to Release Confidential Records and Information (kids)

Client: _____ Date of Birth: _____

I give permission for Dr. Tina Schneider to release and/or request information to/from the following person, agencies, and schools:

School/Teachers _____

Address _____

Phone _____ Fax _____

Pediatrician/Physician _____

Address _____

Phone _____ Fax _____

Other _____

Address _____

Phone _____ Fax _____

Other _____

Address _____

Phone _____ Fax _____

Other _____

Address _____

Phone _____ Fax _____

Other _____

Address _____

Phone _____ Fax _____

This information can include written and verbal data from observation, educational and psychological assessments, IEP's, MFE's, report cards, medical tests, and/or therapy sessions.

Parent/Guardian Signature _____ Date _____

This release is valid for one year from the date of signature and can be revoked at any time by the parent/guardian with written notice to Dr. Tina Schneider.

Witness _____ Revoked Date _____

6264 S. Sunbury Rd. Suite 400 Westerville, OH 43081
PHONE: 614-653-5281 FAX: 614-675-4449 T.Schneider.PhD@gmail.com