Atlanta Neuropsychological Services, LLC
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Board Certified in Clinical Neuropsychology
Board Certified Subspecialist in Pediatric Neuropsychology

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Authorization for Release of Information

I, _____ authorize Dr. Jonathan Dodd to exchange information with the following individuals as part of my psychological assessment process:

Physician _____

Psychiatrist _____

Therapist _____

Other _____

Other _____

This authorization may be revoked by written request at any time to the extent that action has already been taken in reliance on it. If not previously revoked, this authorization will terminate one year from the date indicated below.

I understand the nature and purpose of the authorization, and I had the opportunity to ask questions about it. I understand that I may refuse to sign this authorization. I understand that information to be released may be subject to re-disclosure by the recipient (s) and may no longer be protected by the privacy regulations.

Printed Name: _____

Signature: _____

Date: _____