Atlanta Neuropsychological Services
Jonathan N. Dodd, Psy.D., ABPP
Georgia Licensed Psychologist
Board Certified in Clinical Neuropsychology
Board Certified Subspecialist in Pediatric Neuropsychology

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Suite 575
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770-827-5073
(insert email)

Authorization for release of information

I, _____ authorize Dr. Jonathan Dodd who is assessing

my child _____ to: (*check all that apply below*)

_____ release information to
_____ receive information from
_____ release and receive information / two-way communication

Child's school: _____

Pediatrician: _____

Psychiatrist: _____

Therapist: _____

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: _____

Relationship to child: _____

Date: _____