David Goodman, Ph.D.
Psychologist Associates

Children, Teens, Families, Adults

Release of Information Consent

I, _____
(Client Name) (Date of Birth)

hereby give permission to David Goodman, Ph.D, Psychologist Associates to:

- ❑ Communicate with
- ❑ Receive information from
- ❑ Provide information to
- ❑ Share billing/scheduling information with parent or guardian

Name of facility/person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

The purpose of this disclosure is:

- ❑ Facilitating evaluation and/or treatment
- ❑ Coordinating treatment
- ❑ Share billing/scheduling information with parent or guardian
- ❑ Other (Specify) : _____

Consent is valid until this date unless otherwise revoked: _____

I understand that I may revoke my consent in writing at any time and that David Goodman, Ph.D. Psychologist Associates has the right to inspect and copy the information disclosed. I understand that the refusal to consent to the release of this information may lead to incomplete or inaccurate conclusions or delay in the completion of the evaluation or treatment. Refusal to consent means no information will be released.

Patient signature (Age 12 and older): _____

Signature of Parent/Guardian: _____

If the patient is age 12 or older, the patient **MUST** sign this form. If the patient is under 18 years of age, a parent or guardian also must sign this form.

Date of Consent: _____ Witness Signature: _____

405 Illinois Avenue, Suite 2C
St Charles, IL 60174--4187

405 Illinois Avenue, Suite 2D
St Charles, IL 60174--4187

Tel 630 377 3535
Fax 630 377 6703

davidgoodman@drgoodmanassoc.com
www.drgoodmanassoc.com