



Manhattan Psychology Group, PC

107 West 82nd St Suite P101

New York NY 10024

646-389-4112

Release of Information (ROI) Authorization Form

Client Full Name:

Client Date Of Birth:

Client Address:

Client Mobile Phone Number:

I hereby authorize Manhattan Psychology Group, PC to release and/or obtain the following information in writing and/or verbally for the purpose of educational, psychiatric, and/or medical health planning:

Evaluations (psychological, neuropsychological, psychosocial, etc.)

Medical History

Progress Notes/Updates/Reports

Psychiatric/ER Evaluations

Educational/School Reports

Other

Specify Other:

This authorization is to the specified provider written below

Name of Provider, Institution, and/or Agency:

Provider Title or Role:

Email:

Telephone:

Fax:

I/we hereby authorize the release and exchange of the above information with the specified provider and Manhattan Psychology Group, PC. I/we understand that this consent may be revoked at any time in writing and will expire one year from the date signed below. I understand that the above information after it has been released will be held in a confidential manner; and is not authorized for further release to a third party.

Patient/Parent or Legal Guardian Name:

Date:

Relationship to Patient: