Manhattan Psychology Group, PC
107 West 82nd St Suite P101
New York NY 10024
646-389-4112

# Release of Information (ROI) Authorization Form: Pediatrician/Physician

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 Evaluations/School Reports
- [ ] Other

Specify Other:

**This authorization is to the specified provider written below**

Name of Provider, Institution, and/or Agency:

Name of Physician/Pediatrician:

Email(s):

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: