Child: _____ **Office of Dr. Susan Hill**

RELEASE OF INFORMATION

I authorize Dr. Susan Hill to release or obtain information related to my child's evaluation (including diagnosis, medical/developmental history, test scores, classroom observation, treatment recommendations) to those individuals, school personnel, or agencies listed below. Please note that State Law prohibits the dissemination of evaluative "raw data" to anyone other than a licensed psychologist. Written permission is required before Dr. Hill can exchange information. Once information is released, the potential exists for the information to be subject to redisclosure by the recipient and no longer protected by the Privacy Rule in some instances.

NAME OF THE PERSON ADDRESS/CITY/ZIP	PHONE NUMBER	PURPOSE OF DISCLOSURE (e.g. diagnosis, accommodations, intervention)	RELEASE INFO. BY PHONE OR IN PERSON (allows Dr. Hill to talk with the other person)	RELEASE WRITTEN REPORT (allows Dr. Hill to send a copy of the report)	LIST ANY LIMITATIONS (e.g. Do not Release Diagnostic Info.)**
Physician: _____ Addr:			YES NO	YES NO	
School & Contact Person: _____ Addr:			YES NO	YES NO	
Insurance: _____			YES NO	YES NO	
Other Professionals (e.g. OT, Speech, Tutors, Psychologists): Name: _____ Addr: _____ Name: _____ Addr: _____			YES NO YES NO YES NO	YES NO YES NO YES NO	

** Please note that if any limitations are listed, then a written report will not be released to the professional or agency.

_____ _____ _____

Mother Father Date

Both Parents/Legal Guardian's Signature is REQUIRED; if sole custody, a copy of the custody agreement is required