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AUTHORIZATION TO RELEASE INFORMATION FORM

NOTE: For Verbal Communication Only.
This form is *not* used for written reports.

To: ______________________________	***To:*** ______________________________
(e.g. Physician, Therapist)	*(e.g., Name of School/Facility)*
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Address	*Address*
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City/State/Zip	*City/State/Zip*

I hereby grant permission to release information concerning ______________________________ Date of Birth: ______________________ to Barry Skoff, Ph.D. I also grant permission to Barry Skoff, Ph.D. to release information to the above-named agency or individual. I understand that this information will be kept confidential, and will be used solely for the purpose of evaluation and/or treatment with Barry Skoff, Ph.D. I also understand that this releases Barry Skoff, Ph.D. from any and all legal responsibility or liability that may arise from the act I have authorized.

______________________________	______________________________
Signature	***Date****
______________________________	______________________________
Print Name	***Relationship***

****** This authorization form expires one year from date of signature.***