The Levin Center

1786A Century Blvd.
Atlanta, GA 30345
404-636-7624
www.levincenter.org

AUTHORIZATION TO OBTAIN AND TO RELEASE INFORMATION

Client Name: _____

Date of Birth: _____

I hearby authorize The Levin Center to disclose to and/or obtain information concerning the above named client. In addition, I authorize 2-way phone and/or email communication to gather relevant history and diagnostic information.

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate coordinate treatment services. If other purpose, please specify: _____

Description of information to be disclosed:
____Psychological or Neuropsychological Evaluation (Mental Health information)
____Other _____

Names, Addresses, Phone Numbers of Professionals

NAME:	_____	NAME:	_____
ADDRESS:	_____	ADDRESS:	_____
	_____		_____
PHONE:	_____	PHONE:	_____
EMAIL:	_____	EMAIL:	_____

I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. A photocopy of this authorization shall be as valid as the original.

_____ _____
Signature of Client (age 18 or older) Date
Parent/Legal Guardian (under age 18)

IF CLIENT WITHDRAWS CONSENT

_____ _____
Signature of Client (age 18 or older) Date
Parent/Legal Guardian (under age 18)