Learning Insights
Comprehensive Assessments, A Pathway to Success
120 West Avenue, Suite 103, Saratoga Springs, NY 12866
3548 Route 9W, Highland, NY 12528

Client Name: _____ DOB: _____

I hereby authorize Lenore Strocchia-Rivera, Ph. D., Linda Tafapolsky, Psy. D., Juliana C. Bates, Ph. D., Annetta Scott, Ph. D. and/or Cheryl Engel, Ph. D. to release information to and obtain information from the following person(s) or institution(s) regarding the above-named client for the purpose of completing a psychological evaluation and/or assessment and making appropriate referrals.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that professional services will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Name: _____

Organization: _____

Address: _____

Phone: _____

Type of Information to be Disclosed: _____

_____

If records are being requested, please mail them to:

Learning Insights, PO Box 1214, Highland, NY 12528

This authorization shall remain in effect for:
____ One Year
____ Until Completion of the Evaluation/Assessment

Signature: _____ Date: _____