FAMILY PSYCHOLOGICAL RESOURCES
580 W. Crossville Rd., Suite 201
Roswell, GA 30075
Tel: 770 643-4877
Fax: 770 643-4854

AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

To:_____ DATE:_____
_____ CLIENT:_____
_____ DATE OF BIRTH:_____
Phone:_____ Fax:_____
Purpose or need for release:

Specific Information to be Disclosed Between Dr. Wagner and Authorized Persons:

_____Psychiatric/Substance Abuse History
_____Psychological/Achievement Tests
_____Educational Information
_____Diagnosis
_____Treatment Plan
_____Academic/School Records
_____Lab results
_____Telephone Contact (as needed for coordination of care)
_____Developmental History
_____Medical History
_____Discharge Summary
_____Prognosis
_____Medications
_____Course of Treatment
_____ Other:_____

I understand that, in order to protect the limited confidentiality records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above. The agreement will be effective for:
_____ninety (90)days
_____indefinitely

It is understood that this authorization is subject to revocation at any time in writing, and unless otherwise specified, it automatically expires in one year from the signature date.

Please send information to the following address:
Brenda J. Wagner, Ph.D., A.B.P.P.
FAMILY PSYCHOLOGICAL RESOURCES
580 W. Crossville Rd., Suite 201
Roswell, GA 30075

SIGNED:_____(Parent/Legal Guardian)_____(Date)
_____(Patient 12 years or older)_____(Date)
WITNESS:_____