DIVINE PSYCHOLOGY, LLC
4343 Shallowford Rd, Suite G3-4
Marietta, GA 30062
Phone: 770-449-5152 Fax: 866-821-7683
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AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize:
Divine Psychology, LLC
Dr. Sara Vélez, PsyD
4343 Shallowford Rd, STE G3-4
Marietta, GA 30062
Phone: 770-449-5152

AND:
Person/Facility:_____
Address: _____Phone:_____
AND:
Person/Facility:_____
Address: _____Phone:_____

to exchange information from records about the following individual:
NAME:_____ DOB: _____

for the following purpose(s):
□ Collaboration with Physical Therapists and/or other clinicians at Pro Performance Therapy
□ Collaboration with treatment team at the following facility:_____
□ Collaboration with Physician(s)
□ Further mental health evaluation, treatment, or care
□ Treatment planning
□ Other: _____

If records concern a specific time period it is indicated as such:
The time between _____ and _____.

The information to be disclosed is marked by an X in the boxes below:

	Medical history and evaluation(s)		Neuropsychological report
	Mental health evaluations		Progress notes and treatment summary
	Developmental and/or social history		Educational records
	Psychological report		Other:

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is voluntary on my part. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed.

_____ _____ _____
Signature of Patient/Parent Printed name Date