RALPH BOYNTON, PH.D.

1115 Upper Hembree Road, Suite B
Roswell, Georgia 30076

Phone: 404-663-5502
Fax: 770-475-1171

RELEASE OF INFORMATION

I ____
(Self, Parent or Guardian)

hereby authorize ____

Address: ____
Street City State Zip

Phone: ______________________ Fax: ______________________

To (release) (receive) information from the records of ______________________

(Birth date ____/____/____) for the purpose of:

- ☐ Psychiatric History (including substance abuse history)
- ☐ Developmental History
- ☐ Medical History
- ☐ Treatment Recommendations
- ☐ Course Treatment
- ☐ Discharge Summary
- ☐ Summary of Hospitalization (Date: ____/____/____)
- ☐ Lab Reports, EKG results, EEG results
- ☐ Psychologicals/Achievement Tests
- ☐ Academic/School Records
- ☐ Teachers Observations
- ☐ Attendance Records
- ☐ Child Behavior Checklist
- ☐ CAP Scales
- ☐ Telephone Contact (as needed for coordination of care)
- ☐ Other ______________________

PLEASE FORWARD INFORMATION TO THE ATTENTION OF:

____
(Print Full Name)

Address: ____
Street City State Zip

Phone: ______________________ Fax: ______________________

I have been told 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, and will be effective for (ninety (90) days) (indefinitely) from signature date.

I also understand that I can cancel this consent at any time, except for action which has already been taken.

______________________ Signature of Patient (12 years & older) & Date

______________________ Signature of Parent/Legal Guardian & Date

______________________ Signature of Staff Member & Date