ERN AND ASSOCIATES, LLC
AUTHORIZATION FOR RELEASE OF RECORDS FORM

I hereby give consent to:

Ern and Associates, LLC
c/o: Greg S. Ern, Ph.D., NCSP
State Licensed/Certified/Nationally Certified School Psychologist
1940 58th Avenue, Suite D
Vero Beach, FL 32966
(772) 444-6455

To communicate with and release to:

NAME: _____
ADDRESS: _____
_____
PHONE #: _____
FAX #: _____
EMAIL: _____

Information concerning:

NAME OF CLIENT: _____
DATE OF BIRTH: _____

Information to be released may include any information that is needed to assist in the evaluation, treatment, and/or education of the above named client (i.e., social and developmental history, medical history, educational information such as grades, test results, diagnostic information, educational recommendations, progress monitoring data, standardized test scores, psychological/psycho-educational reports, IEP's or other accommodation or learning plans).

I understand that all client information is confidential and my records cannot be disclosed without my written consent. 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. Without my expressed revocation, this authorization will automatically expire:

_____ Upon receipt of the information requested
_____ After six months from the date of signing
_____ On _____ (date supplied by parent/guardian)
_____ Under the following conditions _____

_____ _____
Client/Parent/Guardian Date

Note: This authorization pertains to any employee or contractor working for Ern and Associates, LLC.