AUTHORIZATION FOR EXCHANGE OF INFORMATION

We at the Hallowell Center would like to ensure quality care, and in doing that we would like to contact your (pediatrician, primary care physician, psychologist, and or therapist, etc.) and keep them informed with regards to the Attention Deficit Disorder Assessment that we are performing. Thus, please complete the following information form below.

I hereby give my consent to the Hallowell Center Clinicians to exchange any information relating to my medical, educational, and mental health history with;

1. Name: _____
   Address: _____
   _____
   Telephone # _____

2. Name: _____
   Address: _____
   _____
   Telephone # _____

3. Name: _____
   Address: _____
   _____
   Telephone # _____

_____ _____ _____
Print patient's name Date of Birth Patient/ Guardian signature

Date: _____