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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

By signing this document, I, _____ hereby authorize Dr. Rami M. Sadeghi to disclose information and records on **myself** (other: _____) obtained in the course of diagnosis and/or treatment to:

Name, Agency, School, or Individual: _____

Address: _____

City & Zip: _____

Telephone: _____

I understand that any cancellation or modification of this authorization must be in writing. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

I give permission to Dr. Rami M. Sadeghi and the agency/person listed above to share the following information:

_____ Educational _____ Psychometric (testing)

_____ Medical _____ Social

_____ Psychological _____ Psychiatric

_____ _____

Signature of Client/Parent/Guardian Date