



Consent to Obtain or Release Information

Patient name: _____

Date of Birth: _____

I hereby authorize staff in Westwood-Mansfield Pediatrics **to obtain information on my child** from:

- School (name) : _____
- Neuropsychologist (name): _____
- Therapist (name): _____
- other : _____

I hereby authorize staff in Westwood-Mansfield Pediatrics **to release information on my child to:**

- School (name): _____
- Neuropsychologist (name): _____
- Therapist (name): _____
- other: _____

Parent/Guardian OR Patient signature

date

The information obtained will be used solely in the consultation by Westwood-Mansfield Pediatrics staff with above named entities. The information received will be considered confidential.

