Ari E. Fox, LCSW-R

168 West 86th Street- Suite 1D
New York, NY 10024
Phone 212-362-0528

AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION

Authorization is hereby given to:

_____

To give information to and receive information from:

Ari E. Fox, LCSW-R
168 West 86th Street
New York, NY 10024
212-362-0528

Regarding: _____
Patient's Name Date of Birth

For the purpose of: diagnostic assessment, treatment planning, and/or treatment.
Nature of information to be exchanged between Mr. Fox and the above named person or agency:

- Evaluation and treatment summaries
- Individual and Family assessments
- Medical Information
- Testing Results
- Academic and behavioral performance

I understand that my consent to release/obtain information is subject to revocation at any time except to the extent that the agency or person has already taken action on it. If not previously revoked, this consent will expire one year from the date of this release.

_____ _____
Patient's Signature Parent/Guardian Signature

_____ _____
Date Date