Dr. Samantha DeCaro, Psy.D.
Licensed Clinical Psychologist

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Authorization to Release Information

Permission is hereby granted to Dr. Samantha DeCaro, Psy.D. exchange information about:

Patient Name: ______________________________________ Date of Birth: ______________________

with the collateral contact named below:

Name: ____

Address: ____

City/State/Zip: ____

Telephone: _______________________ Fax: __________________________________

Relationship to Patient: ____

Dr. DeCaro may provide the collateral contact with the following information:

____Diagnosis ____Treatment Plan ____Psychological Evaluation
____Developmental Hx ____Progress Notes ____Treatment Summary
____Other____

The collateral contact named above may provide Dr. DeCaro with the following:

____Diagnosis ____Psychological Evaluation ____Developmental Hx
____Academic Test Scores ____Medical Hx ____Teacher's Report
____Progress Notes ____School Counselor's Report ____Treatment Plan
____IEP ____Treatment Summary ____Social Worker's Report
____Police Report ____Probation Record/Report ____Discharge Summary
____Dependency Court ____Other____

This information shall be used for the purpose of:

____Treatment Planning ____Evaluation ____Other

I release Dr.Samantha DeCaro,Psy.D. from legal liability arising from the release of this information. I understand that this authorization is valid until I terminate treatment and may be revoked before that time if I request so in writing.

Patient's or Parent's printed name: ____

Patient's or Parent's Signature:____ Date:_________________