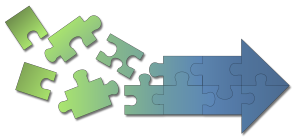

Forward Thinking Assessment

Comprehensive ● Individualized ● Collaborative

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth:_____

I authorize the following party to release information regarding the above-referenced individual to:

Forward Thinking Assessment LLC
4785 Dorsey Hall Drive, Suite 125
Ellicott City, MD 21042

Phone: 443-574-4405
Fax: 443-546-3250

_____ _____
Name of person Phone

_____ _____
Name of organization Fax

_____
Street Address

_____
City State Zip Code

The following information is requested to be released:

[ ] Intake and discharge summaries
[ ] Medical history and evaluation
[ ] Psychological/Neuropsychological evaluations
[ ] Psychiatric evaluations
[ ] Academic or educational evaluations
[ ] Teacher reports
[ ] Speech/language evaluations
[ ] Occupational therapy evaluations
[ ] Academic records (including Section 504 Plan and/or Individualized Education Plan)
[ ] Other: _____

I authorize [ ] Written communication [ ] Verbal communication

This authorization will remain in effect until _____(date not to exceed 1 year).

I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that action has already been taken. I understand that I may request a copy of this form after I sign it. Information received by Forward Thinking Assessment LLC may not be redisclosed without appropriate authorization.

_____ _____
Signature of responsible party Date

_____ _____
Printed name of responsible party Relationship to patient