Barry F. Skoff, Ph.D.
Clinical Neuropsychologist

AUTHORIZATION FOR TESTING & RELEASE OF INFORMATION

I/we, the undersigned parent(s) or legal guardian(s) of_____,
grant permission to Barry F. Skoff, Ph.D. to test/evaluate my/our child.
I also authorize Dr. Skoff to release such information as may be necessary, including sending a copy of the resulting written report to the following individuals, agencies or institutions:

1)_____
(Name)

_____
(Address)

_____
(City/State/Zip)

2)_____
(Name)

_____
(Address)

_____
(City/State/Zip)

I understand that I may withdraw my authorization at any time by submitting a written request to Dr. Skoff. Authorization may be withdrawn except for the following:

- to the extent that action has been taken in reliance on this authorization;
- if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the any information about, including reports of, my child=s condition to those persons or agencies listed above.

_____ _____
(Signature of parent or guardian) (Date)

_____ _____
(Please print name) (Relation to Client/child)