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Consent to Obtain/Release Information

This form allows Glenn Cahn, PhD to obtain and/or release information about myself, or the child

_____, whom I am parent/guardian to.

I authorize Glenn Cahn **to contact** (e.g. school, doctors, professionals) to obtain information about myself/my child (give name and contact info such as phone number or address):

1) _____

2) _____

3) _____

And/or I authorize Glenn Cahn **to release** information about myself/my child to (e.g. school, doctor, therapist, other professionals; give name and contact info such as phone number or address):

1) _____

2) _____

3) _____

This authorization will expire in six months from today, or on the date of _____

I understand I can revoke this authorization at any time by putting in a written request and giving it to Glenn Cahn. I understand that revoking it will prevent any additional contact for or release of information, but can not change what already has transpired.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

Client/parent/guardian

Date