ADHD CENTER FOR SUCCESS
12625 High Bluff Drive #202
San Diego, CA 92130
Phone (858) 481-4988 Fax (858) 792-5095

CONSENT TO RELEASE INFORMATION

I, ____________________________________ hereby authorize the ADHD Center for Success

and/or

______________________________	______________________________
Physician/Pediatrician - Phone	Psychiatrist - Phone
______________________________	______________________________
Teacher - Phone	School Principal/Administrator - Phone
______________________________	
Other - Phone	

to disclose information and/or records regarding:

____
(name of client)

The following information may be disclosed:

_____ All pertinent records/information
_____ Psychological/Psychiatric treatment reports
_____ Medical records
_____ Educational/School records
_____ Diagnostic impressions
_____ Psychological testing reports
_____ Hospital records
_____ Family history
_____ Laboratory tests
_____ Other (describe) ____

Disclosure of records is required for the following purposes:

_____ Psychological treatment _____ Educational planning
_____ Medical evaluation _____ Court request
_____ Other (describe) ____

This consent shall terminate as of ________________________________
(date)

Date ____________________ Name:______________________________

Signed: ____________________________

Witness:____________________________