



A for-profit organization

Kuiper Neurobehavioral Clinic
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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____ Date of Birth _____

I authorize Kuiper Neurobehavioral Clinic, Inc. to exchange with, release to, or receive information from:

1. _____
Name of Person, Agency, or Organization

Street Address

City State Zip Code Telephone Fax

2. _____
Name of Person, Agency or Organization

Street Address

City State Zip Code Telephone Fax

Check All That Apply:

- Psychological testing and evaluation summaries
- Psychiatric evaluations/ summaries/diagnosis/treatment recommendations
- Cumulative files/Special Education files
- Discharge Summaries/Treatment evaluations
- Medical and Physical Histories
- Discussion (as needed) via telephone
- Other (Please Specify) _____

Client Signature _____ Date _____

Parent/Legal Guardian _____ Date _____