Dr. Robert J. McInerney & Associates
Psychological and Neuropsychological Services Ltd

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Authorization For Release of Personal Health Information (Children and Youth)

Name of Child: _____ Date of Birth: _____

In my capacity as the parent or legal guardian of the child named above, I hereby authorize and request that you release the following personal health information from my child's health record at Dr. Robert J. McInerney and Associates Limited:

- ☐ Neuropsychological or psychoeducational assessment reports
- ☐ Verbal discussion of assessment results, mental health, and/or other information pertinent to my child's psychological health (e.g., via phone, videoconference, or in person)
- ☐ Other (specify): _____

This information is to be released to:

Name of Person or Agency: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

Specific Instructions or Limitations (Optional)

_____

_____

_____

This authorization will cover actions by all Associates at Dr. Robert J. McInerney and Associates Limited. This authorization will automatically expire one year from the date of signature. It may be amended or revoked at any time in writing.

_____ _____
Name of Parent or Legal Guardian | Signature of Parent or Legal Guardian

_____ _____
Date | Witness