Colette de Marneffe, Ph.D.
2130 Pine Street
Philadelphia, Pennsylvania 19103
215-645-2565

Authorization to Exchange Information

This form, when completed and signed by you, authorizes me to exchange protected information from your child's clinical record with the person you designate.

I, ____, authorize Dr. Colette de Marneffe to exchange information related to the treatment of (child's name) ____ with the following person:

Name: ____ Telephone: ___________________

Address: ____

This exchange of information is authorized for the purpose of: ____________________________
____.

This authorization to exchange information will remain in effect until ______________________, unless it is revoked in writing prior to that date. I have the right to revoke this authorization at any time by sending written notification to Dr. Colette de Marneffe at the above address.

Signature of Parent: ____ Date: ______________________