Spencer H. Gelernter & Associates, Inc.
3901 Roswell Road, Suite 210
Marietta, GA 30062

Authorization for Request and Release of Psychological/Medical Information

CHILD

I, _____ authorize those listed below to release any relevant information, either verbally or in writing, regarding my child, _____ (Date of Birth) _____ to Spencer H. Gelernter, Ph.D. & Associates.
Parent Initial: _____

I, _____ authorize Spencer H. Gelernter, Ph.D. & Associates to release to the parties listed below any relevant information, either verbally or in writing, regarding my child, _____ (Date of Birth) _____.
Parent Initial: _____

ADULT

I, _____ authorize those listed below to release any relevant information, either verbally or in writing, regarding myself to Spencer H. Gelernter, Ph.D. & Associates. Initial: _____

I, _____ authorize Spencer H. Gelernter, Ph.D. & Associates to release to the parties listed below any relevant information, either verbally or in writing, regarding myself. Initial: _____

Name: _____ Phone _____

Name: _____ Phone _____

Name: _____ Phone _____

Name: _____ Phone _____

Name: _____ Phone _____

Signature: _____ Date: _____

Witness: _____