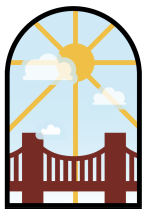

Patricia K. Barr, Ph.D., Clinical Psychologist

PatriciaKBarr@verizon.net
617-460-2745

Authorization for Disclosure of Information to Dr. Barr

To aid in the treatment of _____ DOB _____
I authorize Dr. Patricia K. Barr to obtain information regarding my child(ren) from the following agency or individual:

Name: _____

Address: _____

Phone: _____

Scope: This information may include physical, medical, health, developmental, intellectual, learning, social, emotional, family, behavioral and any other dimensions and components of personal information, past or present, as well as the informant's perceptions, opinions, and conclusions. The information may be released in phone contact with Dr. Barr, in person, or by written records and documentation. Dr. Barr may ask questions which could indicate issues of concern or treatment and may release information as relevant for assessment and treatment. This disclosed information may include otherwise protected information regarding genetic, medical, and other conditions; alcohol or drug use; or other matters. Other than for its careful use in treatment with the family and child, as well as other treatment team members, all information it will be held in confidence by Dr. Barr in accordance with state and federal privacy rules.

Expiration: Unless revoked sooner this authorization expires one year from the date below.

Revocation: The person authorizing this disclosure may revoke (cancel) this authorization by writing a letter or email to and received by Dr. Barr. Obviously, this can not be made retroactive if Dr. Barr has already received the information.

Once your questions or concerns have been answered to your satisfaction please sign below, along with your printed name and date.

Signature: _____

Name: _____ Date: _____