

Spader Psychological Services, LLC

Michelle Spader-Cloud, PSYD, BCBA-D, COBA

Licensed Clinical Psychologist • Board Certified Behavior Analyst • Central Ohio Behavior Analyst
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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Michelle Spader-Cloud, PsyD, BCBA-D to exchange information with the following:

To be Released To (name, address, phone, fax, email)	Information to be Released (see below for more details)	Purpose of this Release (check all that apply)
1)	<input type="checkbox"/> School Information <input type="checkbox"/> Psychiatric/Psychological Evaluation, Testing or Treatment Information <input type="checkbox"/> Medical Information/History <input type="checkbox"/> Other: _____	<input type="checkbox"/> Coordination of Care <input type="checkbox"/> Continuation of Care <input type="checkbox"/> For Evaluation/Treatment <input type="checkbox"/> Insurance/Reimbursement <input type="checkbox"/> Other: _____
2)	<input type="checkbox"/> School Information <input type="checkbox"/> Psychiatric/Psychological Evaluation, Testing or Treatment Information <input type="checkbox"/> Medical Information/History <input type="checkbox"/> Other: _____	<input type="checkbox"/> Coordination of Care <input type="checkbox"/> Continuation of Care <input type="checkbox"/> For Evaluation/Treatment <input type="checkbox"/> Insurance/Reimbursement <input type="checkbox"/> Other: _____

Information to be Released:

- A) School Information (e.g., ETR, IEP, 504 documents ; social, academic, behavioral, emotional functioning)
- B) Psychiatric/Psychological/Neuropsychological Evaluation, Testing, or Ongoing Care Information
- C) Medical Information (e.g, medical history, medical care received)
- D) Other

This release will expire 180 days from the date of signature, unless another date is indicated: _____

I fully understand this request/authorization for release of records between Dr. Michelle Spader-Cloud and the above-named person or facility. I understand that this release can be revoked by me at any time with written notice to all parties. However, the revocation cannot be retroactive to any information already released. I release the above named parties from any legal liability that may arise from the release of the information requested.

Signature of Client (or parent/guardian)

Date

Relationship to Client

Michelle Spader-Cloud, PsyD, BCBA-D (witness)

Date