

LD Neuropsychological Services

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Lana Delshadi, Ed.D. (PSY 16895)

Authorization Consenting Release of Information

I authorize *Lana Delshadi, Ed.D.* to discuss (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation with any person(s) or staff of clinic, office, agency, or institution/s named below and receive any relevant information from them.

1. _____
Specialty: _____ Phone: _____ Fax: _____
2. _____
Specialty: _____ Phone: _____ Fax: _____
3. _____
Specialty: _____ Phone: _____ Fax: _____
4. _____
Specialty: _____ Phone: _____ Fax: _____
5. _____
Specialty: _____ Phone: _____ Fax: _____

For the following reason(s): Consultation/Psychotherapy Evaluation

Other: _____

I may revoke this consent at any time. This consent is in effect for only **five (5) years** from the date of the last session unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in our office policies.

Patient Name: _____ DOB: _____

PRINT NAME SIGNATURE DATE

PRINT NAME SIGNATURE DATE