PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

MICHELLE LURIE, Psy.D., ABPdN

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Authorization Form

I, _____, do hereby authorize Michelle Lurie, Psy.D.; ABPdN to perform a school visit at (NAME AND ADDRESS OF SCHOOL) _____ _____.
I understand that this visit will involve observation of my child, possible interaction with my child, and interview with teachers/principal.

Date of expiration: _____.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Dr. Lurie has taken action in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____
(if applicable)