

Dr. Georgann Norton, Psy.D.
Licensed Psychologist

239-261-1514

RELEASE OF INFORMATION

NAME OF PATIENT: _____

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____
(Street) (City) (State) (Zip Code)

I/WE HEREBY AUTHORIZE: DR. GEORGANN NORTON, PSY.D., Clinical Psychologist

TO RELEASE TO/REQUEST FROM:

ADDRESS

THE FOLLOWING INFORMATION:

____ HEALTH/MEDICAL RECORDS

____ NEUROPSYCHOLOGICAL EVALUATIONS

____ EDUCATIONAL RECORDS

____ PSYCHOLOGICAL ASSESSMENTS AND
DIAGNOSIS

____ CONSULTATION

____ PRIOR TREATMENT RECORDS AND REPORTS

____ SOCIAL HISTORY

____ OTHER (PLEASE SPECIFY)

____ PSYCHIATRIC EVALUATIONS

I understand that I may revoke this at any time (revocation must be in writing). I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by Dr. Georgann Norton, Psy.D. in writing.

Patient Signature
(Age 12 and older must sign)

Date

Parent/Guardian

Witness

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