Charlotte Tilson, Psy.D.
Psychologist

Authorization for the Exchange of Information

Client/Child's Name _____

Date of Birth _____

I authorize the exchange of information between Charlotte Tilson, Psy.D. and the individuals/agencies listed below. This authorization may be revoked in writing at any time and will expire one year from the date of signature below. Any re-disclosure of information by the recipient is prohibited without the express written consent of the parent/guardian listed below. This release includes all educational, psychological and medical records.

I understand that I may be directing Dr. Tilson to disclose health information to a person or organization that may not have the same obligations to protect privacy required of health care practitioners, health plans and other health care entities under state and federal law. I understand that the disclosure of the information specified above may carry with it the potential for unauthorized disclosure of my or my child's protected health information and loss of protection under state and federal law.

Dr. Tilson may exchange information with:

Person or Agency	**Role in Client's Life**	**Telephone/email**

Signature of adult client/parent/legal guardian Date Relationship to client

Signature of adult client/parent/legal guardian Date Relationship to client

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