WILLIAM B. ZUCKERMAN, Ph.D.
Licensed Clinical Psychologist
8987 Cotswold Drive, Burke, Virginia 22015
703-764-0700 Fax/703-764-3068

CONSENT FOR SHARING OF PROFESSIONAL/CONFIDENTIAL INFORMATION

Child's or Client's Name: _____ Date of Birth: _____

_____ Date of Birth: _____

I(we) hereby authorize and request the sharing of confidential information from my contacts with the below listed individual(s) and Dr. William B. Zuckerman or his agents. This information will include, but is not limited to, pertinent social history, psychological testing, psychiatric or other psychotherapeutic treatment, medical information, and educational information, where appropriate. I understand that the information will be used for professional purposes only. Information to be released pertains to the above named child or children.

Name: _____

Title: _____

Address: _____

Phone & Fax: _____

I understand that I may revoke this consent at any time by informing, in writing, the above named individual(s). This consent will automatically terminate one year from the date of signature below.

_____ _____

Witness' Signature Date Signature of Parent or Client Date

_____

Signature of Parent or Client Date

A copy of this document shall be as valid as the original.

*****THIS IS NOT A REQUEST FOR COPIES OF FILES OR RECORDS*****