AMI FLAM KUTTLER, PH.D.
CHILD & ADOLESCENT PSYCHOLOGIST / PSYCHOLOGICAL EVALUATIONS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:

Name: Ami Flam Kuttler, Ph.D.

Address: 4600 Sheridan Street, Suite 400
Hollywood, FL 33021

Phone: 954-881-1211 Fax: 954-983-8307 email: akuttler@bellsouth.net

to obtain and release any medical, psychiatric, educational, psychological, or historical information from and to:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____ email: _____

Concerning: _____
(Patient Name)

I understand that I may revoke this consent, in writing, at any time by informing any of the above noted individuals. All revocations must include the patient's name, address, and date of birth, the date of revocations, and the patient or patient's legal guardian's signature. All revocations must be sent to Ami Flam Kuttler, Ph.D. and are not effective until received.

I hereby release the above parties from all liabilities arising therefrom. This consent, unless revoked in writing, is valid for one year from the date signed.

Please accept a photocopy of this authorization as if it were an original executed authorization.

Patient/Parent/Guardian's Signature: _____ Date: _____

Print Name: _____ Date: _____