Susan K. Daniel, Psy.D.
Family Pinnacle, LLC
761 Maitland Avenue
Altamonte Springs, FL 32701
Phone: 407-740-0208
Fax: 407-740-0242

RELEASE OF CONFIDENTIAL INFORMATION

I _____ hereby authorize release of the following information:

____ Psychological Evaluation
____ Clinical Resume
____ Other records (specify) _____
____ 2-Way Communication

Concerning: _____ Myself _____ Minor child(ren) _____
_____

__ To: Susan K. Daniel, Psy.D.
__ From: 761 Maitland Avenue
Altamonte Springs, FL 32701
407-740-0208

__ To: _____
__ From: _____
_____
Telephone No. _____

I understand that the above information is privileged and confidential and may be released only with my consent, according to applicable laws, rules and ethical standards. I further understand that I may revoke this authorization at any time upon written request and that it will expire one year from this date, if not revoked.

_____ _____
Signature Date

_____
Witness/Notary