

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:
 From: Susan K. Daniel, Psy.D.
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 (if necessary)