Westchester Psychological Services

91 Smith Avenue
Mount Kisco, NY 10549
845-313-9049

www.WestchesterPsychologicalSvcs.com

RELEASE FORM/CONSENT FOR CONSULTATION

Name of Parent/Guardian: ____

Child's Name/Date of Birth: ____

I give permission for members of Westchester Psychological Services (WPS) to speak with my child's teachers, tutors, physicians, and specialists regarding his/her medical, psychological, and/or academic functioning. Members of the practice may also have access to any relevant written documentation. All information received and/or reviewed will be kept confidential and will be used only to assure complete and accurate assessment and treatment of the above named child.

I am comfortable with communication that takes place (please initial):

____ In person

____ Via telephone

____ Via email correspondence

____ Via written correspondence

Parent/Guardian Signature ________________________________

Date ______________