

Dr. David L. Kupfer, Ph.D.
7700 Leesburg Pike, #404
Falls Church, VA 22043
TEL/FAX: (703) 821-8990

Consent for Release of Confidential Information

Date: _____

To: _____

Re: _____

DOB: _____

SSN: _____

_____ David L. Kupfer is authorized to release the following information to the person and/or facility mentioned above:

_____ You are requested to furnish the following information to David L. Kupfer, Ph.D.:

_____ Medical and/or psychiatric evaluation

_____ Psychological or educational testing

_____ School information

_____ Summary of therapy or counseling

_____ Other _____

I accept the use of a photocopy of this consent form as valid. I can revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it. I understand that this authorization expires one year from the date written above, without my expressed revocation or renewal.

Authorizing Signature/Responsible Party

Relationship

Witness

If information has been requested, I appreciate your contacting me by phone or mail at the number and address mentioned above. Thanks for your cooperation.

Sincerely,

David L. Kupfer, Ph.D.