Laurie J. Smith, M.S., CAGS, PLLC
Licensed School Psychologist

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize: Laurie J. Smith, M.S., CAGS, PLLC
10340 Democracy Lane, Suite 104
Fairfax, Virginia 22030

703-938-5234, Ext. 4
703-938-2949 (Fax)
info@lauriesmithpsych.com

To obtain and release all information (written and oral), including but not limited to **medical, psychological, educational, behavioral, and social data** from and to:

Concerning: _____ _____
Client Name **Date of Birth**

Unless otherwise specified, this authorization shall remain in effect until one year from the date noted below.

You have the right to revoke this authorization at any time. Should you wish to revoke this authorization, provide Laurie Smith, M.S. with a written, dated, and signed formal statement to that effect.

Date: _____ Signature: _____
Parent signature/Client signature (if 18 or older)