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## **Consent to Obtain or Release Information**

Pati	ent name:	
Date of Birth:		
I hereby authorize staff in Westwood-Mansfield Pediatrics <u>to obtain information on my child</u> from:		
0	School (name):	
0	Neuropsychologist (name):	
0	Therapist (name):	_
0	other:	-
0 0	eby authorize staff in Westwood-Mansfield Pediatrics <u>to release</u> School (name):  Neuropsychologist (name):  Therapist (name):  other:	
	Parent/Guardian OR Patient signature	date

The information obtained will be used solely in the consultation by Westwood-Mansfield Pediatrics staff with above named entities. The information received will be considered confidential.

