Dr. David L. Kupfer, Ph.D.
3501 Pinetree Terrace
Falls Church, VA 22041
Telephone: (703) 899-5444
Fax: (703) 821-1114
DLKupferphd@gmail.com

Consent for Release of Confidential Information

Date: _____

To: _____

_____

Re: _____

DOB: _____

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

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

_____ 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.