

*THE S.T.E.P. GROUP*  
*School Testing & Educational Placement*

RELEASE OF INFORMATION

I am completing this form to allow the use and sharing of protected health information about:

Printed Name of Child: \_\_\_\_\_

Date of Birth of Child: \_\_\_\_\_

I hereby authorize Dani Levine, Ph.D. (License Number PSY 15573) to use or disclose and/or exchange any of the following information: Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries or other diagnoses, prognoses, recommendations, or testing records and behavioral observations or checklists by any and all professionals with knowledge of the above-referenced child. If the services rendered by Dani Levine, Ph.D. include placement, this Release of Information will include all programs or schools in which Dr. Levine will be considering.

The information and or documentation indicated may be exchanged via phone, e-mail and/or facsimile with Dr. Levine and the following professionals:

\_\_\_\_\_  
\_\_\_\_\_

(Name, Address, Phone Number of Professional)

Printed Name of Parent or Guardian: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_