Aoife Lyons, Ph. D.
Licensed Clinical Psycologist

# Dr. Aoife Lyons and Associates

## Consent for Release and Exchange of Information

1655 W. School
Chicago, IL 60657
Phone: 773-244-3151
Fax: 773-880-1315

I _____ authorize Dr. Aoife Lyons and Associates to send ____ and or

Receive _____ the following information (please check relevant areas below) from the

following organizations or individuals:

| _____ | _____ | _____ |
|---|---|---|
| (Name of party) | (Address) | (Phone/fax) |
| _____ | _____ | _____ |
| (Name of party) | (Address) | (Phone/fax) |
| _____ | _____ | _____ |
| (Name of party) | (Address) | (Phone/fax) |

The following information (please check)

_____Psychological testing results

_____Treatment Plan

_____School Behavior and Performance

_____School Report Card

_____ School Individualized Educational Plan (IEP) and/ or Case Study Reports

_____ Results of Standardized Testing

_____Therapy Notes (from psychologists and/ or social workers)

_____Medical Reports

_____ Occupational Therapy

_____ Speech and Language Therapy

_____Other _____

By signing this consent for release and exchange of information, I understand that:

1) This information will be used for treatment planning.
2) I have the legal right to review/ copy any of the documents disclosed.
3) I can withdraw this consent at anytime. It will automatically expire one year from the date of signature below.
4) All information will be kept strictly confidential. Neither party may pass information on to a third party without an addition consent.

Aoife Lyons, Ph. D.
Licensed Clinical Psycologist

_____
(Signature of client) Date

_____ _____
(Signature of parent or guardian, if other than patient) (Relationship and date)

_____
(Signature of clinician) Date

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