

Colette de Marneffe, Ph.D.  
8720 Georgia Avenue, Suite 205  
Silver Spring, MD 20910  
301-891-2120

**Authorization to Exchange Information**

This form, when completed and signed by you, authorizes me to exchange protected information from your child's clinical record with the person you designate.

I, \_\_\_\_\_, authorize Dr. Colette de Marneffe to exchange information related to the treatment of (son/daughter) \_\_\_\_\_ with the following person:

Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Address: \_\_\_\_\_

This exchange of information is authorized for the purpose of: \_\_\_\_\_  
\_\_\_\_\_.

This authorization to exchange information will remain in effect until \_\_\_\_\_, unless it is revoked in writing prior to that date. I have the right to revoke this authorization at any time, by sending written notification to Dr. Colette de Marneffe at the above address.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_