Dear Parent(s):

In order to assist in your child's diagnosis and treatment, we request pertinent information, including any psychoeducational or speech and language evaluations, any Individual Education Plan (IEP) or Section 504 plan, and or psychological testing information.

We ask that you complete these forms as soon as possible, as we are unable to complete your child's evaluation. The forms can be faxed or emailed back to our office.

The S.E.L. Group
3300 Battleground Avenue
Suite 202
Greensboro, NC 27410

336-285-7173 – phone
336-285-7174 – fax
contact@theselgroup.com

Thank you for your assistance and cooperation.

Nannette S. Funderburk
Dr. Nannette S. Funderburk, Ph.D., LPCS
Psychotherapist

ADHD Testing Form

Client First Name	Client Last Name	Date of Birth

Evaluators		
Name	**Role (Father, Mother, Teacher, etc.)**	**Email Address**

Each evaluator will be given an assessment to complete on behalf of the client.

Client / Parent / Guardian (Print Name) ______________________________

Client / Parent / Guardian Signature: ________________________________

Date: _______________

AUTHORIZATION TO RECEIVE / DISCLOSE HEALTH INFORMATION

Client Name	
Date of Birth	
Person Authorizing Release	
Relationship to Client	
Recipient / Organization to Receive/Disclose (Name / Address / Fax)	

This data shall include (please check data to be received or disclosed)

- o Assessments
- o Psychiatric Evaluations
- o Psychological Evaluations
- o Diagnoses
- o Progress Notes
- o Treatment Plan / Goal
- o Discharge Summary
- o Financial Obligations
- o Substance Abuse/Treatment
- o HIV / AIDS Information
- o Other ________________________

Purpose of Release or Disclosure

- o At the request of individual
- o Court proceedings
- o Assessment / Evaluation
- o Determination of benefits
- o Coordination of Care

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

______________________________	______________________________
(Signature of Client)	(Date)
______________________________	______________________________
(Signature of Personal Representative)	(Date)