WEST END
NEUROPSYCHOLOGY

Dr. Jennifer Lumpkin, Psy.D., ABPP

3108 N. Parham Road, Suite 100C
Richmond, VA 23294

(804) 205-7452 (phone)

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I,_____,HEREBY AUTHORIZE
Patient's name

Jennifer C.M. Lumpkin, Psy.D., ABPP, Licensed Clinical Psychologist, 3108 N. Parham Road, Suite 100C
Richmond, VA 23294

To disclose the following health information

- □ Intake report
- □ Neuropsychological/psychological report
- □ Treatment summary
- □ Discharge summary
- □ Other: _____

to the following individual or organization:

_____
Name

_____
Address

_____
Telephone

_____
Fax

If I check the following box, the individual or organization named above may also disclose information to Dr. Lumpkin for the purposes described above. □

As the person signing this consent, I understand that I am giving permission for Dr. Lumpkin to disclose confidential information or records. The release of information is effective for one year from the date below unless revoked in writing by the patient. A copy of this consent will be included in my original records.

_____

Patient's Name and Date of Birth

_____

Patient's Signature

_____

Date

_____

Clinician's Signature

_____

Date