CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

_____	_____
Name of Patient	**Name of Doctor/Organization**
_____	_____
Date of Birth	**Street Address**
_____	_____
Street Address	**City, State, Zipcode**
_____	_____
City, State, Zipcode	**Phone Number/ Fax Number**

I hereby authorize: Dr. _____ of
Brain Performance & Psychology Center
10291 N. Meridian St., Suite 310
Indianapolis, IN 46290
Ph: 317-672-1970 / Fx: 317-672-1971

And the organization or person designated above to exchange the necessary information concerning me and/or my child for the purpose of:

_____

[This consent shall apply to all information available and is in affect for the next 180 days unless a more limited time period is indicated here: _____.]

I understand that I may revoke this request in writing at any time, but this request shall remain until revoked, or upon expiration of 180 days, whichever comes first.

In consideration of this consent, I hereby release the above party from any legal liability resulting from the release of this information.

_____	_____
Patient/Parent Guardian Name Printed	**Witness Name Printed**
_____	_____
Patient/Parent Guardian Signature	**Witness Signature**
_____	_____
Relationship to Patient	**Date Witnessed**