PROGRESSIONS
DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

AUTHORIZATION FOR RELEASE / EXCHANGE OF INFORMATION AND RECORDS

- I hereby request the release / exchange of all medical records, reports, questionnaires, medical information, psychological / mental health information, and all information related to the diagnosis and assessment, treatment, prognosis, and recommendations, as well as other data pertinent to the treatment and care of my child. This information will be used for assessment, diagnosis and treatment of my child:

- **Patient's Name:** _____ **DOB:** _____

- **Parent/Legal Guardian Name:** _____

TO/FROM: (List Names of Primary Care Physician, School and any Specialists)

_____

_____

_____

_____

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_____

FROM/TO: Brad Berman, M.D.
Progressions: Developmental and Behavioral Pediatrics
1801 Oakland Blvd., #340
Walnut Creek, CA 94596

- This authorization is valid for one year. I acknowledge receipt of a copy of this authorization.
- A photocopy of this authorization shall be considered as effective and valid as the original.
- Notifying this office in writing may revoke this authorization.

- _____ _____
  Signature of Parent/Guardian/Patient Date

- _____
  Relation to Patient

REV 10/3/2013