

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable private information as described below. I understand that this authorization is voluntary. I understand that this authorization allows *only the release* of private information between the persons or organizations providing the information and the person or organization receiving the information, viz., Kenneth W. Reagles, Ph.D., and K.W. Reagles & Associates.

Client Name: _____

I D O R S S N U M B E R : _____

Persons or Organization *Providing* This Information:

Person or Organization *Receiving* This Information:

Kenneth W. Reagles, Ph.D.
K.W. REAGLES & ASSOCIATES, LLC
Bridgewater Place, Suite 550
500 Plum Street, Suite 550
Syracuse, New York 13204

Please provide the requested specific information for each item checked:

- Physical, occupational, and allied health medical records, including diagnoses, treatment, prognoses, case notes, and discharge summary.
- Therapy records, including functional capacity evaluation reports, specifically _____.
- Psychological test reports, summaries, and test summary data.
- Psychotherapy notes and summaries.
- Telephone consultation or collateral interview.
- Employee records, including performance reviews.
- Labor union data, including wage and fringe benefits, dues, and hours worked per year.
- Vocational evaluation reports, summaries, and test summary data.
- Vocational rehabilitation case file contents, (e.g., agency records, including rehabilitation plans, rehabilitation counselor case notes, completed agency forms, services provided, and case disposition).
- O t h e r (s p e c i f i c a l l y) :

The **purpose** for which the information is requested is to assist K.W. Reagles & Associates in determining loss of economic capacity, employability potential, lost capacity to perform work within the home environment, prepare a life-care plan, or for related purposes.

I understand that this authorization is valid for up to **12 months** following the date of my authorization. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions taken before the revocation was received.

Signature

Date

You may refuse to sign this authorization.