



Chesapeake ADHD Center
of Maryland

Specializing in Attention and Learning Disorders

CONSENT FOR EXCHANGE OF INFORMATION

I hereby authorize _____ and the Chesapeake ADHD Center to exchange information concerning:

_____ (Client Name, DOB)

With:

Name: _____

Address: _____

Phone: _____

I understand that the information will be used for professional purposes only and may include results of assessments and communication with Chesapeake Associates. I have noted below information which can be discussed/exchanged: _____

This consent will automatically terminate on: _____
(Date must not exceed one year.)

Client name

Client signature
(or Parent signature if client is under 18)

Date

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Kathleen G. Nadeau, Ph.D., Director

Updated 2/18/2008