

TAMARA L. KAISER PhD LICSW LMFT

AUTHORIZATION FOR RELEASE OF INFORMATION Current Supervisor/Consultant

I _____ agree to give Tamara L. Kaiser, PhD

LICSW, LMFT permission to give to and receive information from

_____ about my work as a supervisee __ /consultee __

during the following time period: from _____ to

_____ for purposes of collaboration regarding my practice while

Tamara L. Kaiser serves as my clinical supervisor for licensure __ /consultant __.

Name of Current Supervisor/Consultant _____

Address of Current Supervisor/Consultant _____

Phone Number of Current Supervisor/Consultant _____

Fax Number of Current Supervisor/Consultant _____

Signature of Supervisee/Consultee

Date