

TAMARA L. KAISER PhD LICSW LMFT

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client

Name of Second Client (if Couple)

Address

I/We authorize:

Name of Individual and/or Organization

Address

To release to:

Name of Individual and/or Organization

Address

Information from the records maintained while involved with that facility during the time period of _____
_____. The information to be disclosed is:

_____ Two-way

_____ Intake reports

_____ Progress summary

_____ Consultation report

_____ Legal reports

_____ School reports

_____ Psychological testing reports

_____ I.Q. testing reports

_____ Educational proficiency reports

_____ other – specify: _____

This information is requested for the following purposes: _____

The information released by this authorization shall not be re-released.

I understand that I may revoke this consent at any time by written notice and that upon fulfillment of the above stated purposes or at the end of one year, whichever is first, this consent will automatically expire.

Signature of Client

Date

Signature of Second Client (if Couple)

If Minor, signature of Parent or Legal Guardian