Client Name________________________

Authorization to Release Information

I, ___________________________________, (client or authorized healthcare representative) give permission to Kirsten Kuzirian, PsyD to release and provide to:

____

(Name)

____

(Address)

____

(Phone)

the following information: (check all that apply)

_____ attendance in therapy

_____ diagnosis

_____ treatment plan

_____ coordination of care

_____ assessment information collection

_____ other (please explain in detail)

____

____

I understand that this release is valid for 1 year. I further understand that I may revoke this authorization at anytime in writing.

In consideration of this consent, I hereby release the above parties from any legal liability resulting in the release of this information.

____

(Signature) (Date)