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

Tamara L. Kaiser is an employee of Tamara L. Kaiser, LLC, a Minnesota Limited Liability Company // 2233 N. Hamline Avenue #207, St. Paul, MN 55113 // office 612-825-8053 // fax 651-765-1834