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