Keely Kolmes, Psy.D. **CA License: PSY21284**

Authorization to Release Information

I, _____, the undersigned, give permission to Keely Kolmes, Psy.D. to release and provide to:

_____
(Name)

_____
(Address)

_____
(Phone Number)

the following information (check all that apply)

☐ my attendance in therapy

☐ my diagnosis

☐ my treatment plan

☐ information relevant to coordinating care

☐ when treatment is terminated and why

☐ other (please explain in detail) _____

_____

I understand that that this release is valid for a period of 120 days. I further understand that I may revoke this authorization at any time in writing.

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

_____ _____
Signature Date