

## 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 the extent of treatment unless revoked in writing. I further understand that I may revoke this authorization *at any time* in writing. If you wish this release to be valid for a shorter term, please indicate the date it shall expire:

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date