

Authorization to Release Information

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

(Name)

(Address)

(Phone Number)

(Fax Number)

the following information (check all that apply):

- my attendance in therapy my diagnosis
- my treatment plan information relevant to coordinating care
- 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