AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Alishia Kalos, PsyD, by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Alishia Kalos, PsyD to:

_____ release to: _____
_____ obtain from: _____
_____ exchange with:
_____
_____

the following information pertaining to myself:

_____ therapy summary
_____ history/intake assessment
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of therapy attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment
_____ coordinating therapy efforts
_____ other (specify): _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Date of Birth:_____
Signature of Client Date
(See below for extension of authorization)

_____ Date of Birth:_____
Signature of Client Date