AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

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

I ____ authorize Alishia Kalos, PsyD, CST to: (insert name)

_____ release to: ___________________________________ (select one and insert name,
_____ obtain from: _________________________________ address, and phone/email
_____ exchange with: contact information)

____
____

the following information pertaining to myself: (select all that apply)

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

for the purpose of: (select all that apply)

_____ 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 #1 Date

____ Date of Birth:___________________

Signature of Client #2 (if applicable) Date