Catherine M. Malkin, Ph.D., LLC
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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I authorize Catherine M. Malkin, Ph.D., LLC to:

_____ Release to the following _____ Receive from the following

_____
Name/Title/Facility

_____
Street Address

_____
City/State/Zip Code

_____ _____
Phone Number Fax Number

_____ School Information (social, academic, behavioral, emotional functioning)
_____ Psychiatric/Psychological/Neuropsychological Evaluation, Testing, or Ongoing Care
_____ Medical Information
_____ Other: _____

Record Information NOT TO BE RELEASED: _____

Purpose of this release: _____ Continuity of Care _____ For Evaluation/Treatment
_____ Insurance/Reimbursement _____ Other: _____
_____ Coordination of Care

This release will expire at the end of treatment, unless another date is indicated: _____

I release the above named parties from any legal liability that may arise from the release of the information requested. I understand that this release can be revoked by me at any time with written notice to all parties. The revocation cannot be retroactive to any information already released.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if client is a minor) Date

_____
Relationship to Client (if client is a minor)

_____
Witness