KATHRYN S. STEINMAN, PSY.D.
Licensed Psychologist

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ________________________, authorize Kathryn S. Steinman, Psy.D. to discuss with and/or obtain from ____ all pertinent information, copies of reports, or other data related to my intellectual and/or psychological functioning, treatment, counseling, and prognosis. The purpose of this release of information is:

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By initialing below, I approve that Dr. Steinman may contact the above individual by the following means:

_______ Phone: ________________________________

_______ Email: ________________________________

_______ Fax: ________________________________

This authorization will remain in effect until treatment is terminated. I am aware that I have the right not to provide authorization for disclosure of the above-stated information. If I do give consent, I understand that I may revoke my authorization at any time by providing such revocation in writing.

________________________________ ________________

Patient Signature Date

7910 Woodmont Avenue / Suite 1101 / Bethesda, MD 20814
kathrynsteinman@gmail.com / Phone: 301.787.4459