

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 the intellectual and/or psychological functioning, treatment, counseling, and prognosis of my child,

_____.

The purpose of this release of information is: _____

_____.

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.

Parent/ Guardian Signature

Date