KATHLEEN D ROBINSON PsyD LLC
Licensed Psychologist
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Phone 303-782-0433
Fax 303-756-1413

I, _____, authorize Dr. Kathleen Robinson to:
(Name of Client or Parent/Legal Guardian)

_____ release confidential records to
_____ receive confidential records from
_____ verbally communicate with

_____
(Name)

_____
(Address)

_____

_____
(Phone & Fax)

Regarding: _____
(Client)

for the purposes of treatment coordination, continuity of care, and other purposes relevant to psychological treatment.

_____ _____
(Client / Parent Signature) (Date)

_____
(Address)

_____
(Phone)

This release of information is valid for _____ months.