Royce B. Garvin, Ph.D.
Licensed Psychologist PSY 9077

Authorization for Release of Information

1. Client's Name:____
2. Information to be released : Summary of treatment to date; Report;
   Other:
   ____
3. Purpose of Disclosure Coordination of Care
   ____
4. Persons authorized to make Disclosure:
   ____
5. Person authorized to receive Disclosure:
   ____
6. Method of Disclosure
   Written : ____
   Verbal:____
   Electronic: ____
7. Today's date:______________________________
8. Authorization to expire on: _________________

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of
Client:____Date:_______________