KIMBERLY LAWRENCE KOL, PSY.D.
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CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize Kimberly Lawrence Kol, Psy.D. to release
(patient's name or parent of patient's name)

information in my/my child's psychiatric record to:

_____
name of organization or provider

_____
address

_____
phone/fax

I also authorize this organization/provider to release information in my psychiatric/medical record to Kimberly Lawrence Kol, Psy.D.

This consent for release of information is limited to the following dates of treatment:

from _____ (indicate date of initial session)

to _____. (indicate "no limit," date one year from initial session, or other end date)

_____
signature of patient/parent of patient

_____
date