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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.

signature of patient/parent of patient

date