Katherine Tomkinson, M.Sc. R.M.F.T.
Individual, Couple and Family Therapy
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AUTHORIZATION TO RELEASE INFORMATION

Client's Name: ____
Address: ____
____

Date of Birth: ____/____/____
(day/month/year)

I_____________________________, hereby authorize the **Katherine Tomkinson**
(client's name)

to release to ___________________________________, information contained in my Clinical Record
(agency, organization, school, hospital, professional)
as follows *(state type of information below):*

____

For the purpose of:____

I______________________________ , hereby authorize______________________________________ to
(agency, organization, school, hospital, professional)
release **to Katherine Tomkinson**, information contained in my Clinical
Record as follows *(state type of information below):*

____

For the purpose of:____

Such information shall be released in accordance with my instructions as set out and initialed below:

A. ____________ I authorize you to release information verbally;

B. ____________ I authorize you to release information in writing;

C. ____________ the written information referred to in "B" above may **NOT** be delivered by facsimile or any other form of electronic communication

I agree that this authorization continues in force until _____________________ (date – Maximum 1 year) unless I revoke it in writing prior to that date.

______________________________________ ___________________________
Signature Date

__________________________________ ___________________________
Witness Date