

Kimberley Taylor, Psy.D.
Clinical Psychologist
PSY14415
1215 De La Vina Street, Suite F
Santa Barbara, CA 93101
(805) 568-3700

Authorization For Release Of Information

I, _____ Date of Birth _____
(Patient)

hereby request and authorize _____
(Professional)

to release and exchange written or verbal information as specified below to:

Name

Address Phone

- I. All medical, legal, and mental health evaluations, history and therapy including illegal substance abuse, abuse reports, HIV, and consultations.
- II. I understand that the information will not be used for any purpose other than its intended use.
- III. I understand that I have the right to refuse to sign this Authorization or revoke my consent at any time prior to the release of information.
- IV. I understand that this information is to be used for the purpose of coordination of medical and mental health care and/or insurance purposes.
- V. The professional (above) is not authorized to disclose information to any other person/entity without my consent. Any further disclosure is strictly prohibited.

Name (printed): _____

Signature: _____ Date _____

Signature of Witness: _____ Date _____