Dr. Catherine Cauthorne
DrCauthorne.com

Authorization to Release Information

Patient: _____ DOB:_____

I hereby authorize Dr. Catherine Cauthorne, Ph.D., Licensed Psychologist to receive information regarding myself from or to release pertinent information to:

_____ _____
Name Address

_____

_____
Telephone

Pertinent records/information on: _____

for the purpose of :

_____

_____

This authorization is fully understood as to the nature of the information and the implications of its release, and is made voluntarily on my part.

I understand that I may revoke this consent at any time within 90 days except to the extent that action based on this consent has been taken. This consent expires automatically after 90 days from date of signature, or upon fulfillment of the above purposes.

_____ _____ _____
Date Patient Signature Parent/Guardian Signature

_____
Witness Signature