KINGSBURY COUNSELING | Josh Kingsbury, Ph.D.
LICENSED PSYCHOLOGIST

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Authorization for Release/Request of Confidential Information

Permission is hereby given to Josh Kingsbury, Ph.D. to release and/or exchange information for professional use from the records of:

Client Name:____

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

The type of information is limited to (check at least one):

[ ] any and all information [ ] psychological
evaluation(s) [ ] discharge summary/report [ ] confirmation of services

[ ] treatment summary [ ] drug and alcohol issues

[ ] intake summary/report [ ] other

[ ] with the following exceptions____

The information should be released to, received from, and/or exchanged with:

Name:____

Address:____

Telephone/Fax:____

This authorization shall remain in effect until: _________________________

I understand that I may revoke this consent at any time by notifying my therapist, Josh Kingsbury, Ph.D., in writing. I also hereby release Josh Kingsbury, Ph.D., from any liability in connection with the release of the above information.

Client Name:____Date of Birth:_______________

Address:____

Signature:____Today's Date:_______________

Dr. JoshKingsbury:______________________________________Today's Date:_______________