Jill L. Kofender, Ph.D., P.L.L.C.
Licensed Clinical Psychologist

AUTHORIZATION TO REQUEST OR RELEASE CONFIDENTIAL INFORMATION

Client's Name_____ Date of Birth_____

Name of Parent/Guardian, if minor_____

I hereby authorize Jill L. Kofender, Ph.D. to request/release/exchange information with the following individual, provider, or institution:

Name of Individual/Provider/Institution_____

Address_____

Telephone_____ Fax_____

Specific Information to be Requested/Disclosed:

_____

_____

Purpose of Disclosure_____

This authorization shall expire on the following date _____

Signature of Client, or Parent/Guardian_____Date_____