Dr. Kimberly Rubin Ph.D.
Licensed Psychologist

AUTHORIZATION FOR THE RELEASE OR EXCHANGE INFORMATION

Clients Name:_____ **D.O.B.:**_____

Information May Be: ☐ Released To ☐ Received From

Individual/Agency:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **Email:**_____

Information to be Released or Exchanged:

☐ **All Records** ☐ **Medical History** ☐ **Psychiatric Evaluation** ☐ **Psychological Test Results**
☐ **Diagnosis** ☐ **Family System Evaluation** ☐ **Educational Records** ☐ **Educational Test Reports**
☐ **Attendance Records** ☐ **Psychosocial Reports** ☐ **Lab Results**

☐ **Other** *(Please Specify)*_____

This release is an active authorization until revoked by Dr. Kimberly Rubin Ph.D..

_____ _____
Signature of Client, Parent or Guardian **Date**

_____ _____
Dr. Kimberly Rubin Ph.D. **Date**

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