ROBIN I. ELLIS, PSY.D.

T 818-730-8491

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Birthdate: _____

I hereby authorize *(physician, school official, probation officer, or other agency)*:

Name: _____
Address: _____
Phone: _____
Fax: _____

to release information from the records of the client identified above to **Robin I. Ellis, Psy.D**, and allow **Robin I. Ellis, Psy.D.** to release information to the person/institution stated above.

Information to be limited to:_____

Date signed: _____ Expiration date: _____

Client signature: _____