

Kathy Khoie, Ph.D.
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CONSENT TO RELEASE/ EXCHANGE INFORMATION

I-----authorize

Kathy Khoie, Ph.D. to provide/ release / exchange information pertaining to myself or
my child (please circle one),

to/with:-----

(name of insurance company, provider, attorney, etc.)

Address-----

Phone-----Fax-----

A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Name of Client (please print)

Signature of Client / Parent / Legal Guardian/ Attorney
Please circle one

Date

Signature of Client / Parent / Legal Guardian/ Attorney
Please circle one

Date