

Robin Goldstein-Lincoln, MA, LPC
Licensed Psychotherapist
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AUTHORIZATION TO REQUEST/RELEASE INFORMATION

I, _____: _____: _____
(Client's last name) (First name) (Middle name)

(Date of birth)

Hereby authorize Robin Goldstein-Lincoln, MA, LPC to **REQUEST/RELEASE** the following information concerning me FROM/TO:

(Name of person or agency) (Phone number)

(Street address) (Fax number)

(City, state, zip code)

ITEMS AND INFORMATION TO BE RELEASED: (This section must be completed.)

I understand that I may revoke this authorization to release information at any time by giving written or verbal notices to Robin Goldstein-Lincoln, MA, LPC. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality. I hereby release Robin Goldstein-Lincoln, MA LPC, from any liability whatsoever in furnishing such information. I agree that a copy/ fax of this form is as valid as the original.

(Signature of client or parent / Date)

(Signature of witness / Date)

Authorization Revoked: Date _____