COLLINS' PSYCHOLOGICAL THERAPY & CONSULTING, Inc.
4455 Murphy Canyon Rd. 100-9
San Diego, California 92123
858-536-8985

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give permission to Dr. Linda Collins to release information about my child's psychological diagnostic assessment and/or treatment to:

☐ No one

☐ My Insurance Company ____

☐ Dr.______________________________ Phone # ____________________

☐ Dr.______________________________ Phone# ____________________

☐ Other____________________________ Phone# ____________________

Signed____ Date_____________

AUTHORIZATION TO RECEIVE TREATMENT INFORMATION

I hereby give permission to Dr. Linda Collins to obtain treatment information about my child from :

☐ No one

☐ My Insurance Company ____

☐ Dr.______________________________ Phone # ____________________

☐ Dr.______________________________ Phone# ____________________

☐ Other____________________________ Phone# ____________________

Signed____ Date_____________

*Please note: This release can be revoked at any time and is only in effect for the duration of your psychological treatment with me