AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize
(Client Name)

Dr. Matthew Leibsohn to release the following checked information to

_____ / _____.
(Provider Name) (Phone)

- ☐ **Therapeutic & Health Information**
- ☐ **Psychological Testing & Reports**
- ☐ **Intellectual/Achievement Testing & Reports**
- ☐ **Insurance Information**

- **This Release of Information is good for six months, and may be cancelled at any time by written request.**
- **This document allows for two-way transfer of written and verbal information.**

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

_____ _____
Dr. Matthew Leibsohn **Date**

WA Licensed Psychologist, #1764
Phone: 425-453-7722