Kari Wolman Killianey, Psy.D.
617 Veterans Blvd., Ste. 107, Redwood City, CA 94063
510-798-5513 • kari.killianey@gmail.com
www.drkarikillianey.com

Consent to Release Information

I hereby authorize Kari Wolman Killianey, Psy.D., to release my medical information to the individual or organization listed below:

Name: _____

Phone:_____ Fax: _____

Address: _____

City/State/Zip:_____

This person is my (circle one):

*Therapist *Family Member *Psychiatrist *Primary Care Physician *Case Manager/Social Worker

*Other:_____

Dates Seen: from_____ to _____

Reports to be Furnished/Verbal Information Requested:

_____ Psychiatric Evaluation and Assessment Reports ____ Progress and/or Discharge Reports
_____ Treatment Plan ____ Medication Information
_____ Other

This authorization shall remain valid until _____ or for one year (based on signature date below), whichever comes first, and may be revoked in writing at any time. Information released per this Consent will not be further used or disclosed, unless authorized, except where permitted by law. A fax or copy of this document shall be valid.

_____
Printed Name of Client

_____ _____
Signature of Client Date

_____
Printed Name of Legal Guardian (for minors)

_____ _____
Signature of Legal Guardian (for minors) Date