Katie Dine Young, Psy.D.
Licensed Clinical Psychologist
2325 Lime Kiln Ln STE A~ Louisville, Kentucky 40222
Ph: (502) 438-0506

Authorization for Release of Confidential Information

Client: _____

Date of Birth: _____

SSN: _____

Regarding the above named client, the undersigned hereby authorizes

Katie Dine Young, Psy.D. to release and/or obtain the information specified below to and/or from:

_____
Agency/Individual

_____
Address **Phone/Fax Number**

Initial / Initial

_____ **Psychological /Educational evaluation(s)**

_____ **Medical records/Psychiatric Evaluation**

_____ **Dates of Treatment**

_____ **Treatment plan**

_____ **Recommendations for current and future treatment**

_____ **Compliance with court orders**

_____ **Professional consultation and/or coordination of treatment (ongoing)**

_____ **Co-Parenting plan/agreements developed**

_____ **Other relevant communication**_____

_____ _____
Client/Parent or Guardian Date Client/Parent or Guardian Date

_____
Relationship to Client

_____
Witness Date

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE OF SIGNATURE. THIS AUTHORIZATION IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN PRIOR TO REVOCATION.