



Fulton Psychological Group

Cynthia Levy, Psy.D.
Psychologist PSY 29085

FAX: 818.591-3041

Authorization to Release Information

Patient: _____

Address: _____

I hereby authorize Cynthia Levy Psy.D. to disclose and/or receive from

(name)

(phone #)

information pertaining to my (or my child's) psychological services rendered from:

_____ to _____.

Specific information requested includes: _____

This authorization is good until: _____

This authorization allows Dr. Levy to discuss information described above and can be cancelled at any time in writing by the patient.

Signature: _____ Date: _____
(parent, if patient is a minor)

Dr. Levy's signature: _____ Date: _____