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LICENSED PSYCHOLOGIST
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DR. EZUST
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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

Date: _____

I authorize: Stephanie L. Ezust, Ph.D. and Gus Kaufman, Ph.D.
Address above

() to release to:

() to obtain from: The therapist and other mental health professionals I currently see (please list name and contact information).

- (x) Report(s) of psychological evaluation
- (x) Summary report of psychotherapy
- () Complete medical / psychological record
- (x) Other (specify): ___General information regarding individual treatment and DBT

I release Dr. Stephanie Ezust and Dr. Gus Kaufman from all legal responsibilities or liability that may arise from this authorization. This authorization is in effect for the entire length of treatment or earlier if I specify in writing.

Client/Patient Printed Name

Parent, Legal Custodian or Guardian

Client / Patient Signature

Therapist