Karen Crane, Psy.D. Licensed Psychologist

5970 Fairview Road
Suite 412
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704-458-8188

Authorization for Release of Information

I hereby authorize **Karen Crane, Psy.D.** to release confidential clinical information to the provider(s) indicated below to aid in treatment planning and coordination. This release is valid for two years, unless otherwise stated. I acknowledge that this consent is voluntary and that I may revoke this consent at any time, except to the extent that action based on consent has been taken.

Patient Name: ____ DOB: _____________

Provider Name: ____
Phone #: ____
Fax #: ____
Address: ____
____

Provider Name: ____
Phone #: ____
Fax #: ____
Address: ____
____

_________________________________ _________________________ ______
Patient Signature Printed Name Date

_________________________________ _________________________ ______
Parent/Guardian Signature Printed Name Date