Sunshine Collins, PsyD
Licensed Psychologist
Clinical, Forensic, & Family Psychology

## AUTHORIZATION FOR RELEASE OF INFORMATION

**This form authorizes Sunshine Collins LLC and:**

| | |
|---|---|
| Third Party Name: | Phone: |
| | Fax: |
| | Email: |
| Third Party Name: | Phone: |
| | Fax: |
| | Email: |
| Third Party Name: | Phone: |
| | Fax: |
| | Email: |
| Third Party Name: | Phone: |
| | Fax: |
| | Email: |

**to exchange all records and information regarding the identity, history, evaluation, testing (including raw data), diagnosis, and treatment for:**

| | |
|---|---|
| Patient 1 Name: | Date of Birth: |
| Patient 2 Name: | Date of Birth: |
| Patient 3 Name: | Date of Birth: |
| Patient 4 Name: | Date of Birth: |

**This request is made voluntarily for professional purposes. I can revoke this authorization by giving written notice to Sunshine Collins LLC. A photocopy of this authorization will be as valid as the original.**

| | |
|---|---|
| Printed Name | Signature |
| Relationship to Patient 1 | Date |
| Printed Name | Signature |
| Relationship to Patient(s) 2 - 4 | Date |