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:

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

Patient 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	Date