Julie Bindeman, Psy-D
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____, hereby authorize Julie

Bindeman, Psy-D, a psychologist in private practice at the above location, to release, and exchange information with:

____

(Name of individual(s) and/or agency from whom information is to be obtained)

at (address and/or phone)____

about myself or my child .

Additionally, I consent to ____ sharing,
(Same name of above professional individual or agency)

releasing, and exchanging information with Julie Bindeman, Psy-D.

The information being released and shared will be used for treatment planning and co-ordination.

I understand that I may revoke this consent at any time except to the extent that action

has already been taken on it and that it will expire automatically by ____________________.
(Date of expiration)

____________________________ ______________________________

Signature of Client/Parent (if client is a minor) Date