KAREN ROBIE, PH.D.

Psychologist, licensed in Ohio and Michigan

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Consent for the Release of Information

Patient Name: _____

Birth Date: _____ SSN (Last 4): _____

☐ Karen Robie, Ph.D., 4930 N Holland Sylvania Road, Suite B, Sylvania, OH 43560

☐ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

is authorized to release and/or exchange confidential information contained in the psychological, psychotherapy, clinical, medical, hospital, school or related records, including protected alcohol and drug abuse records, if any, as well as information regarding communicable diseases and infections such as AIDS, HIV, or ARC, if any, of the individual named above to/with:

☐ Karen Robie, Ph.D., 4930 N Holland Sylvania Road, Suite B, Sylvania, OH 43560

☐ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Approximate date(s) of treatment/services: _____

Specific information is to be released or exchanged:

☐ Diagnostic Summary/Evaluation Results	☐ Testing/Assessment Results	☐ Treatment Plan
☐ Treatment Course and Progress	☐ Medications Prescribed & Med History	☐ Discharge Summary
☐ History/Physical Exam	☐ Educational Evaluation (including psych)	☐ IEP
☐ Drug & Alcohol Use & Related History	☐ _____	

Specific information to be EXCLUDED: ☐ None, or _____

Purpose and need for information release/exchange: ☐ Further care and treatment, ☐ Billing/Insurance requirement, ☐ Coordination of care, ☐ Other: _____

This authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance on it. Upon revocation of consent, no further release of information shall occur. Unless revoked, this authorization will be continuous for the course of treatment with Karen Robie, Ph.D. Information provided under the terms of this authorization may be discussed with the patient named above. Otherwise, it shall be held as confidential and will not be re-released by Dr. Robie without written authorization of the releasing entity to do so and we ask the same courtesy of entities we release information to.

_____ _____
Patient's Signature Today's Date

_____ _____
Parent/Guardian/Legally Authorized Representative's Signature Today's Date

_____ _____
Witness's Signature, if needed Today's Date