

Robyn Coughlin, LCSW

8885 Rio San Diego Drive

Ste: 365

San Diego, CA 92108

619-997-5310

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, give full authorization to ROBYN COUGHLIN, LCSW to furnish information regarding my mental health information to:

Name _____

Address _____

City, State, Zip _____

for the purpose of _____. This consent is subject to revocation by the undersigned, and remains in force for 365 days from the date of signature. By signing and dating this release of information, I allow the person listed below to share specific record information.

Name _____

Address _____

City, State, Zip _____

Client's Signature

Mental Health Representative

Date