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AUTHORIZATION for RELEASE of CONFIDENTIAL INFORMATION

I (print name), _____

DATE OF BIRTH: _____

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TO RELEASE MY COMPLETE PSYCHIATRIC RECORD,

TO: CLINICIANS AT PSYCHopinion.com, LLC

VIA FACSIMILE: 1-800-282-5143

OR

EMAIL: CONTACT@PSYCHopinion.com

SIGNATURE: _____

DATE: _____

WITNESS: _____

This release is in effect until such time that expressed written cancellation is made.