Darnyl R. Katzinger, Psy.D.
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Serving Children, Adolescents and Families

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

I hereby request and authorize: Darnyl R. Katzinger, Psy.D.
3990 Clairmont Road
Atlanta, GA 30341
(404) 909-9500

To obtain from and release to:

1. ____

2. ____

3. ____

the following types of information from my records and/or specific portions thereof:

______All records

______Exclusions

for the purpose of: ____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without my consent. I understand this authorization includes release of all medical records including Human Immunodeficiency Virus records, Psychiatric, Drug/Alcohol Abuse records, Venereal Disease and any other statutory protected disease records. This authorization and consent will remain in effect until I revoke this authorization and consent. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance hereof.

Signature of Patient or Legal Guardian: ____________________________________

Date: ___________________________