COLLEEN KELLY MS LMFT
psychotherapist specializing
in couples & families

To/From: _____
(3rd Party Name)

_____
(3rd Party Address)

_____
(3rd Party Phone Number)

Regarding: _____
(Patient's Name – Print)

I hereby authorize the release of my confidential records to/from Colleen Kelly.

Patient or Guardian's Signature: _____

Date: _____

Note: This form is valid for one year from the date of signature.

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