

Kate Ainslie, Psy.D.

Adolescent and Adult Psychotherapy

PSY # 20455

Release of Information

I, _____, give Kate Ainslie, Psy.D. permission
to release or exchange information about my child: _____
and their treatment with the following party:

This permission expires 2 years from the date of signature.

Signature: _____

Date: _____