Robyn Coughlin, LCSW
8690 Aero Drive
STE: 115-219
San Diego, CA 92123

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