Robin Luband, Psy.D.
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White Plains, NY 10605
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Release of Information

Date: _____

Client Name: _____

I authorize Robin Luband, Psy.D., to exchange information with:

Name: _____ Telephone: _____

Address: _____

_____

for the purpose of collaboration.

Client Signature: _____

Print Name: _____

If client is under 18 years:

Parent Signature: _____

Print Name: _____

You have the right to revoke this authorization, in writing, at any time by sending me written notification.