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RELEASE OF INFORMATION

My signature below releases Robin Scott Walker, M.A., M.F.T. from confidentiality regarding myself and/or my minor child, _____.
I authorize Robin Walker to communicate with the below-named individuals and institutions for the purpose of gathering and exchanging information relevant to his psychotherapeutic treatment of me and/or my child. This information may include, but is not limited to: clinical impressions, family history, social history, educational history, medical treatment, psychological testing, etc.

_____

_____

_____

_____

A photocopy of this release shall be considered valid.

This release expires one year from the date below.

Print Name _____

Signature _____

Date _____