AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I _____ Date of Birth _____

Authorize _____

to release personal information about me to Natalie Kollross, PsyD Licensed Clinical Psychologist to assist in her psychological evaluation of me. I understand that such information will be retained by Dr. Kollross under my privilege and that I may revoke this privilege at any time prior to her completing her written report for my attorney. I further understand that I and my attorney will review the information, which will be held confidential under attorney-client privilege until such time that I decide to release the report.

SIGNATURE_____ Date_____

WITNESS _____ Date _____