

**KAREN TRUESDELL BIERMAN, PHD, PC**

LICENSED PSYCHOLOGIST

160 Creekside Park, Suite 202

Bulverde, Texas 78163

Telephone: (830) 438-9211; Facsimile: (830) 438-7585

**AUTHORIZATION TO RELEASE INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am authorizing the listed below parties to release or disclose to one another regarding my (my child's) case.

Karen Truesdell Bierman, Ph.D.  
160 Creekside Park, Suite 202  
Bulverde, Texas 78163  
Phone (830) 438-9211 Fax (830) 438-7585

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

This request is made voluntarily for professional psychological purposes. I can revoke this authorization by giving written notice to my health service provider. If not revoked this form will be valid for one year from the date signed. A photocopy of this authorization will be valid as the original.

\_\_\_\_\_  
Signature (if child, then legal guardian)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date