Authorization for Release of Information

Client name: _____

Date of birth: _____

SSN (or last 4 digits): _____

I authorize the exchange of medical, psychological, legal, therapeutic, and/or educational information, including, but not limited to, assessment, treatment plan, diagnosis, dates of service, therapeutic goals, discharge information, psychological/psychiatric information, school information, financial records, and other, between Rhona Rosenblatt, LCSW, and :

Name: _____
Title: _____
Address: _____
Phone: _____
Fax: _____

I grant my permission, without limitation, to release this information: Yes No
I grant my permission to receive, without limitation, information: Yes No

I understand that this form must be filled out completely before any information is released. I understand that this authorization for the release/receipt/exchange of information will be valid until revoked in writing. My revocation will be upon written receipt and written acknowledgement, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization. I understand these records are protected by California Welfare and Institution Code 5328, and that additional consent must be obtained for any other transfer or disclosure of information.

Please note that therapist does not provide reports to be used in court, nor in any divorce/custody proceeding, and is not a custody evaluator. Further explanation and terms are provided in the Informed Consent document.

This authorization shall become effective on _____ (date), and if not revoked earlier, will terminate on _____ (date), and should not exceed one year from effective date. I understand that I have a right to receive a copy of this authorization if I request it.

Signature of client: _____
Signature of parent/legal guardian, if minor: _____