AUTHORIZATION FOR RELEASE/REQUEST OF
CONFIDENTIAL PATIENT INFORMATION/MEDICAL RECORD

Client's Name_____
Date of Birth_____

I, the above-named client, hereby authorize Jeri Ryan, Ph.D., 6239 College Ave., Suite 303, Oakland, CA. 94618 510-878-0254

to disclose to_____

Address_____

City_____State_____

Phone Number_____

to receive from_____

Address_____

City_____State_____

Phone Number_____

the following information with the knowledge that it discloses information related to my mental and physical health as well as any court-related information. This disclosure is for the purpose of coordination of treatment services and is limited to the following:

This consent is subject to revocation at any time. It will expire automatically on Date_____ or upon the occurrence of the following:_____
_____

I understand that the person/organization receiving the above information, under Federal regulations and HIPPA, may not disclose this information further unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

Signature of client_____Date_____

Other person authorized to sign (print name)_____

Signature of other person authorized to sign_____

Date_____

Name of Witness (Print name)_____

Title_____

Signature_____Date_____