JEFFREY D. RISSER, L.C.S.W.

2600 E. BIDWELL STREET, SUITE 180 | FOLSOM, CA 95630 | 530-208-8684
JDRCOUNSELING@GMAIL.COM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ DOB: _____

Client Name: _____ DOB: _____

Child Name: _____ DOB: _____

Child Name: _____ DOB: _____

Date of Authorization: _____

Date of Termination: _____

AUTHORIZATION INITIATED BY:

INFORMATION TO BE RELEASED: Authorization for Psychotherapy Notes, Summary, and Health Information regarding Clients and Children. Ability to communicate with:

Authorization and Signature: I/We authorize the release of confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of the confidential protected health information.

CLIENT SIGNATURE: _____ **DATE:** _____

CLIENT SIGNATURE: _____ **DATE:** _____

SIGNATURE OF REPRESENTATIVE: _____ **DATE:** _____

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____
(*for minor children*)

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____
(*for minor children*)