Rachel Robbins, Psy.D.
Licensed Clinical Psychologist
Lic. # Psy22646

Authorization for Release of Information

Name_____

This will authorize:

Rachel Robbins, Psy.D.
Licensed Clinical Psychologist
425 Gough St.
San Francisco, CA 94102
(415)625-9778
rachel@drrachelrobbins.com

To release information to:

Name/Phone

_____

Address

_____

The following information (choose one):

I understand that this disclosure of my medical information will include the information about the following, and, only if I check the box[es].

( ) Yes - Participation in psychotherapy
( ) Yes - Treatment for alcohol and/or drug abuse
( ) Yes - Treatment Records

Other: Specify the records that you authorize to be disclosed:

_____
_____
_____
_____

AUTHORIZATION: I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting a request in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may not be protected by federal privacy regulations. This authorization will not expire unless otherwise stated. I understand that this request may result in an administrative copying fee.

Date of expiration (optional):_____

_____	_____	_____
Client Signature (or Legal Representative)	Date	If Legal Representative, Relationship to Client
_____	_____	
Signature of Witness	Date	