Sarah K. Ravin, Ph.D.
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AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client's Name: _____

Date of Birth: _____

This will authorize Dr. Sarah Ravin to release and receive general medical, psychiatric, and/or psychological information from my record,

TO / FROM:

Name of Individual: _____

Name of Agency: _____

Address: _____

City/State: _____

Telephone #: _____

Email address: _____

Fax #: _____

The Specific Information Requested is:

_____

_____

_____

_____

For the purpose of: ☐ Evaluation & Continuing Treatment ☐ Other (specify):

I understand that I have the right to refuse to sign this authorization, and that the member named above as the releasing agent is released from all legal liability that may arise from the release of the information requested. I further understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected (under Title 42 of the Federal Code) and that re-disclosure of this information by the receiving agency is prohibited.

This authorization is for a ☐ single, or a □ continuing disclosure, which is valid for one year after the date of my signature as it appears below.

Signature of Client: _____ Date: _____

Signature of Witness: _____ Date: _____