Colleen Russell, Licensed Marriage and Family Therapist (MFC29249)
Certified Group Psychotherapist
1036 Sir Francis Drake Blvd, Kentfield, CA 94960
crussellmft@earthlink.net
415-785-3513

Re: ______________________________
Name of Client

____
PO Box, Street Address **City** **State** **Zip**

Release of Confidential Information

Authorization to Disclose Protected Health Information

I hereby authorize _Colleen Russell, LMFT (Provider), to disclose to __________________ (Recipient) the following protected health information:

Any information related to individual, couple, family, or group psychotherapy sessions and consultations, including but not limited to presenting condition, assessment, treatment plan, diagnosis, symptoms, and progress to date.

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:

To open communication between the above-named provider and recipient regarding coordination of care

I understand that Provider cannot condition treatment upon me signing this authorization.

Provider is authorized to disclose the protected health information specifically listed above until:

____Indefinitely_________________(authorization expiration date).

By: ____ Date: _________________
Signature of Client