Rachel Christensen, MSW, LCSW
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Authorization to Release Confidential Information

I, (Name of Client)_____ hereby authorize (names of individuals to whom information will be exchanged or released)

_____ _____

_____ _____

and **Rachel Christensen, LCSW**, to exchange my health records and confidential information obtained during the course of my treatment.

This authorization permits the release of the following information:

- ▫ Any and All Information Necessary
- ▫ Diagnosis ▫ Treatment Plan ▫ Prognosis
- ▫ Progress to Date ▫ Clinical Test Results ▫ Dates of Treatment
- ▫ Patient Records ▫ Summary of Treatment ▫ Other_____

I authorize the release of the information described above for the following purpose(s):

- ▫ Coordination of Treatment (other mental health professional)
- ▫ Medication consultation (doctor or psychiatrist)
- ▫ Family consultation and/or meeting
- ▫ Ecclesiastical Leader (Bishop) ▫ consultation ▫ financial only

The recipient may use the information described above solely for the following purpose(s): Mental Health Consultation. Any limitations, please describe:

_____

This consent shall expire six months from your last contact with Rachel Christensen. You may request a copy of this authorization. You have the right to refuse to sign this form. You understand that the information that is used or disclosed according to this authorization may be subject to re-disclosure by the recipient. The provider will not make providing treatment a condition of signing this Authorization. You are entitled to receive a copy of this form. For revocation of this form, you must provide a written request to the clinician named above. California law may provide additional protection regarding the possible re-disclosure stated above.

By: _____ Date: _____
Signature of Client