IN Psych CENTER
A Licensed Clinical Social Worker Corporation

127 EAST THIRD AVE., STE 201
ESCONDIDO, CA 92025
T: 760/489-1092 F: 760/738-8128
INPSYCHCENTER.COM

AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I, (**name of client**) _____, (hereinafter "Client") hereby authorize **Rachael Stracka, LCSW** , (hereinafter "Provider") to disclose or obtain mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to/from: _____

_____

(Name, Address, Phone, Fax)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization 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. And, I also understand that such revocation must be in writing and received by **Rachael Stracka, LCSW, 127 East Third Avenue, Suite 201, Escondido, CA 92025,** to be effective.

PURPOSE: This disclosure of information and records authorized by Client is required for the following purpose:

_____

USES & LIMITATIONS: The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to):_____

LIMITATION: Such disclosure shall be limited to the following specific types of information:

_____

_____

RIGHTS: Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain **valid until**: _(One year from date)_____

Patient Name: _____ Date: _____ Signature: _____

Or

Legal Representative: _____Date: _____ Signature: _____