1901 NORTH CENTRAL EXPY. STE 220 RICHARDSON TX, 75080
(972) 680-8986 OFFICE (972) 680-9216 FAX

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)** _____ (hereinafter "Patient") hereby authorize **(name of psychotherapist)** Keri Riggs, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

Name: _____
Phone Number _____
Address _____
Fax Number: _____

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 Provider at 1901 North Central Expressway Suite 220, Richardson , TX 75080 to be effective.
This disclosure of information and records authorized by Patient is required for the following purpose:

_____

_____

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

_____

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

_____

_____

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient 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: _____
Patient or Parent/Guardian's signature: _____
Patient or Parent/Guardian's name (please print): _____
Therapist's name: Keri Riggs MA, LPC-S
Date: _____