Dr. Sara

Dr. Sara Ruebelt, PhD, LMFT
132 E Street, Suite 320
Davis, CA 95616
530-302-7322

Authorization for Release of Patient Information

Dr. Sara Ruebelt shall not condition treatment or payment based on this authorization. The patient may refuse to sign the authorization. If the authorization is not signed, the information shall not be released except when required by law. Upon request, the patient may inspect or be provided a copy of the protected health information to be disclosed by this authorization.

Patient Information

Name	Phone Number
Address	City, Zip Code
Date of Birth	Social Security Number

I hereby authorize:

Program/Agency Information	Phone Number Fax Number
Address	City, Zip Code

To release the following information:

□ Entire Record □ Social History

□ Diagnosis □ Individual Treatment Plan

□ Psychiatric Evaluation □ Results of Psychological Testing

□ Discharge Summary □ School Information (Academics/Behaviors)

□ Other _____

To the below agency:

Program/Agency Information	Phone Number Fax Number
Address	City, Zip Code

Dr. Sara

Dr. Sara Ruebelt, PhD, LMFT
132 E Street, Suite 320
Davis, CA 95616
530-302-7322

Authorization for Release of Patient Information

The disclosure of information is required for the purpose of

□ Assessment

□ Treatment Planning

□ Other _____

The information disclosure under this authorization may be subject to re-disclosure by the recipient if allowed or required by law. This authorization is effective as of the date signed and shall expire _____ (not to exceed one year from the date of signature). This authorization may be revoked in writing by the undersigned at anytime except to the extent that action has already been taken.

I understand that I am to receive a copy of this authorization.
□ I decline to receive a copy of this authorization

By signing below, the patient agrees to the above terms in regards to the exchange of confidential information.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Agency Representative Name	Agency Representative Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date