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Authorization for Release of Information - Adult

I have been informed that under California law communication between a client and his/her treatment provider is privileged and may not be disclosed by the provider unless the client consents. I also have been informed that client records maintained by a provider may not be disclosed to third parties except with the client's consent or through the legal process.

I hereby authorize my therapist to video and/or audio record sessions for the sole purpose of review in supervision.
Check here if you do not authorize video ____ Check here if you do not authorize audio _____

I hereby authorize Greenhouse Therapy Center Staff to disclose, release, and/or obtain records to/from the following persons and/or entities:[1]

Greenhouse Therapy Center	Therapists, Supervisors, Administrative Assistants
Prior therapist(s):	
My primary care physician:	Dr.
My psychiatrist:	Dr.
The person who referred me:	
My insurance company:	
My family member(s) as listed:	
Other:	
Other:	
Other:	

This authorization is only for the limited purpose of releasing information to and discussing my case with these persons and/or entities for the purposes of evaluation, treatment, and coordination of care.

This authorization shall remain in effect until revoked by me in writing or termination of treatment.

_____ _____ _____
Printed Name Signature Date

_____
Client Name

[1] Releasing information, particularly in the bolded categories, helps provide a team-treatment approach and the best quality of care. Please provide contact information including phone number and mailing address.