jennifer ritter

COUNSELING

Authorization for Release of Confidential Information

Client or Minor Child/Children's Name/s: _____

Date of Birth/s: _____

Please list the contact information for any relevant provider/organization for whom you authorize to exchange information to and or from Jennifer M. Ritter regarding the client or minor child/ren listed above.

Person/Clinic/Organization Name: _____
Address: _____
City:_____ State:_____ _Zip:_____
Phone:_____Email:_____

☐ I authorize the release of information from the above provider to Jennifer M. Ritter.
☐ I authorize the release of information from Jennifer M. Ritter to the above provider.

Please select the types of information that may be released:

☐ All Mental Health Records
☐ Mental health record summary
☐ Intake/Assessment
☐ Treatment plan
☐ Therapy notes
☐ Verbal/email exchange
☐ Other: _____

Please select the reason for the release:

☐ Ongoing Treatment
☐ Coordination of care
☐ Legal issues
☐ Court ordered therapy
☐ Other: _____

1. I understand that this document authorizes the release of confidential information by the client or the client's legal guardian only. Records requested by attorneys or other parties must be court ordered.
2. I understand I may revoke this authorization at any time by written notice to the address indicated above, and this authorization will cease to be effective on the date notified except to the extent action has been taken in reliance upon it.
3. I understand my treatment will not be conditioned on whether I sign this Authorization. However, if I do not sign this Authorization, I understand aspects of my treatment may be affected. How treatment may be affected will be further discussed with the treating therapist.
4. I understand I can request a copy of this Authorization after I sign it. I hereby release all parties stated herewith from any liability resulting from release of this information.

Parent/Guardian Signature: _____Date: _____