AUTHORIZATION OF RELEASE OF INFORMATION

I _____ am a client and/or parent guardian and hereby authorize **Linda M. Rio, M.A.** ("Provider") to disclose and receive treatment information necessary for mental health treatment

To: [**write the *name of the person or entity to whom disclosure is made*]**

_____

Phone/contact information: _____

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 to reliance upon it. And, I also understand that such revocation must be in writing and received by Linda Rio to be effective.

This disclosure of information and/or records is required for the following purpose: _____

_____

_____

As the client(s)/guardian, you have the right to refuse to sign this form.

Client(s)/guardian 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 Federal Privacy Rule, although such information may be protected by applicable California law.

This authorization shall remain valid until: _____ or until the conclusion of treatment if not specified.

Signed:

Client:_____ Date: _____
Client:_____ Date:_____
Client:_____ Date:_____
Client:_____ Date:_____
Client:_____ Date:_____
Client:_____ Date:_____

For Minors:
Signed by Parent/ Legal Guardian:

_____ Date:_____

_____ Date:_____