Client's Full Name: ____

Date of Birth: ____

I authorize:

Rachel Rippel MA, LP
12301 Whitewater Drive suite 30. Minnetonka, MN 55343
952.466.6002/952.955.4411

To release information to and from: ____

Phone/Fax: ____

Address: ____

Relation to this person: ______________________________________

Information which may be released includes (check appropriate boxes):

[] ALL
[] Discharge Summaries
[] History and Physical Exams
[] Two-way communication between physicians and therapists
[] Phone Contacts
[] Medication Information
[] Psychological Tests / MMPI
[] Other ______________________

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: DO NOT release records regarding: [] mental health [] chemical dependency [] HIV/AIDS

Dates of information to be released: [] All [] Other

This information may be released for the purposes of:

[] Planning/continuing my care and treatment
[] Billing/financial
[] Emergency contact
[] Other ______________________________

Your signature indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices*. You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections

Revocation Clause: I understand that I may withdraw my authorization by written notice. My authorization will expire when I am terminated as a client from the clinic or if I revoke this release in writing.

Client Signature: ______________________________________ Date: _______________

Parent or guardian signature: ______________________________ Date: _______________

Please fill out a release of information for anyone you want me to be able to talk to. I require one for your emergency contact, primary physician, psychiatrist or any other professional involved in your care.