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AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, (Client) _____, DOB _____ hereby authorize Provider, Jozeffa Greer, and the provider listed below to release and exchange mental health treatment information and records obtained in the course of psychotherapy treatment for the sole purpose of coordinating care between providers.

Provider's Name: _____

Address: _____

Phone: _____

I understand that I have the right to refuse to sign this form.

I understand that I have a right to receive a copy of this authorization.

I understand that I have the right to revoke or modify this authorization at any time, unless Provider has taken action in reliance upon it.

I understand that any revocation or modification must be in writing and received by Provider at 1116 22nd Street, Sacramento, CA 95816.

This disclosure of information and records authorized by Client is required for the following purpose:

_____

_____

The specific uses and limitation of the types of information to be discussed are as follows:

_____

This authorization shall remain valid until: _____

Client's signature: _____

Provider's signature:_____