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Rachel Robbins, Psy.D.
DIVERGENT WORLDS
psychotherapy and consulting

Release of Information

Name:	Legal name if applicable:

Your relationship to client (Put an X by the answer):

Self		Parent/Legal Guardian		Personal Representative		Other	

I authorize Rachel Robbins, Psy.D. to send or receive information with the party stated below:
If you select send and receive, both parties can communicate information.

Send		Receive		Send and receive	

Information from (person authorized to share information with):

Name:	Phone Number:
Email if available:	

The following information (Put an X by your responses and mark all that apply):

Mental Health History		Progress notes, and treatment or closing summary		Medical History	
Developmental and/or social history		Educational records		Other	

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Signature _____ Date _____