DR. ROBIN RISLER
CLINICAL PSYCHOLOGIST

Authorization for Release of Information

I hereby request and authorize Dr. Robin B. Risler to disclose to:

_____
_____
_____

The following information:

_____
_____
_____
_____

This information may be used for the purpose(s) of: _____

_____
_____
_____
_____

I understand that:

1. My consent to disclose this information can be revoked. However, mental health information disclosed before the receipt of written revocation may be used for the purposes stated above.

2. This authorization applies only to the disclosure of mental health information which exists as of the date of this document.

3. The information disclosed in accordance with my authorization cannot be further disclosed by the recipient without my consent, unless otherwise authorized by law.

4. Within the provisions of the Mental Health Information Act, I have a right review the mental health information contained in my record.

_____
Signature of Patient

_____
Date of Signature

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