

Counseling & Coaching Center of Roseville



Leilani Jennings, Ph.D.
PSY15579
1380 Lead Hill Blvd., Suite 110
Roseville CA 95661
(916) 956-7762 fax (916) 786-3080

AUTHORIZATION TO RELEASE INFORMATION AND RECORDS

CLIENT _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____

I, _____, authorize the following person(s)/agency to mutually exchange/release information with Leilani Jennings, Ph.D., either in written or verbal format.

Person or Agency: _____

Address: _____

Phone: _____

Specific records may include medical, psychiatric or chemical dependency and are as follows:

The purpose of the information release is as follows: _____

A photocopy or fax of this shall serve the same purposes as an original.

I fully understand this Authorization and Request to Release or Obtain Records and Information from my records as to the nature of the records, their contents, the consequences and implications of its release, and my request is wholly voluntary on my part. I hereby release the source of these records from any liability arising from their release. I authorize the parties above to talk by telephone about my referral, diagnosis, treatment, and similar topics relevant to the above listed purposes for this release of records. I understand that provision of services is not contingent upon this releasing of records. I understand that I may revoke this consent at any time within 1 year except to the extent that action based on this consent has been taken. This consent will automatically expire after one year from the date on which it is signed, or upon fulfillment of the above purposes.

Signature of Client _____ Date _____

Signature of Parent/Guardian/Representative and Relationship

Witness _____ Date _____