Alyssa Steiger, Psy.D.
Clinical Psychologist PSY25784

(628) 227-6278
dralyssasteiger@gmail.com

AUTHRORIZATION FOR RELEASE OF INFORMATION

For purposes of coordinating and monitoring healthcare and treatment, the following individuals/agencies are hereby released to communicate with each other on the behalf of:

Alyssa Steiger, Psy.D.
150 Shoreline Hwy
Mill Valley, CA 91942
415-297-9697

And

_____
_____
_____
_____

Client Name: _____

I specifically request that the following information be released:

- [ ] Mental health and medical history, including diagnosis
- [ ] Records of outpatient treatment
- [ ] Records of hospitalization and inpatient treatment
- [ ] All diagnostic, psychological assessments
- [ ] Forensic records including Court Documents and sentencing reports
- [ ] Other: _____

For the following purpose:_____

This consent will expire exactly one (1) year from the date of signing. I have discussed issues concerning privacy and confidentiality and this consent with Dr. Steiger. This authorization for use and disclosure of medical information is being authorized by me giving Dr. Steiger permission to disclose medical/psychiatric record and information obtained in the course of the diagnosis and/or treatment of my child or me. I may revoke this authorization at any time, in writing to Dr. Steiger except to the extent action has been taken in reliance upon this consent.

I understand that the medical records and information to be released may contain information pertaining to psychiatric, drug, and/or alcohol related evaluation and/or treatment, and may also contain confidential HIV/AIDS related information, including educational, psychological, and laboratory test results.

_____ _____
Client's Signature Date

_____ _____
Parent or Guardian Signature Witness (when signature by X)

Federal regulations (42 CFR) prohibit the recipient from making any further disclosure of this information except with specific written consent of the person for whom it pertains.