C. ALLEN RUYLE, LCSW
Individual, Couple & Group Psychotherapy
333 Olive Street
San Diego, California 92103

619-213-3000 (Voice) • 866-302-7589 (Fax) • Allen@AllenRuyleTherapy.com

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

By completing this form, you are authorizing the release and/or exchange of your individually identifiable health information as outlined below. This is consistent with California and Federal law concerning the privacy of such information. All information requested below must be provided for this Authorization to be valid.

I, _____ Date of Birth_____, hereby authorize C. Allen Ruyle to release and/or exchange confidential information obtained during the course of my treatment to _____.

(Name and/or organization to which information is to be released).

This Authorization permits the release and/or exchange of the following information:

____ All health/mental health information necessary for the purpose(s) specified below.

____ Only the following records or type of information: _____.

____ The follow records or type of information is specifically excluded: _____.

I authorize release of the information described above for the following purpose(s) only:

_____

and understand that California law prohibits recipients of my health information from redisclosing it except with my written authorization or as specifically required or permitted by law.

Unless I revoke it, this authorization shall be effective immediately and remain in effect for one year or **until services are completed** or until _____.

A photocopy or facsimile of this form is to be considered as valid as the original.

_____ _____ _____

Client/Guardian Signature *Client Date of Birth* *Date*

To Revoke Authorization Only:

Authorization Revoked on _____/_____/_____

_____

Signature of Client/Guardian