Rita Bryce, JD, LISW

Child, Adolescent and Adult Therapist

19910 Malvern Rd
Suite 212
Shaker Heights, OH 44122
Phone: 216-438-1905

Authorization for Consent and Release of Information*

Name of Client:	**Date of Birth:**
	Home #:
Address:	**Work #:**
	Cell #:

I hereby authorize Rita Bryce to ____ Release information to: _____ Receive information from:

Name: **Relationship:**

Address and Phone Number:

Reason records are needed:

This authorization expires one year from the date of signature or on this date/event:

I understand that if I release records to someone other than a doctor, insurance company, hospital, or other related organization, these records may no longer by protected by Federal privacy regulations, and this person or organization might release these records to someone else.

I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify Rita Bryce in writing.

Signature of Patient/Parent/Legal Guardian	**Printed Name of Patient/Parent/Legal Guardian**	**Date**
Signature of Witness	**Printed Name of Witness**	**Date**

***The state of Ohio mandates that social workers report suspected abuse of children, the elderly or the disabled regardless of consent. For clients under 18 years of age, parents or guardians sometimes have access to confidential information.**

Notice to Recipient of Records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.