Rainer Geissler, M.A.

Licensed Marriage & Family Therapist (MFC 48467)
870 Market Street, Suite 1101 & 45 Franklin Street, Suite 319- San Francisco, CA 94102
Phone: 415.999.1049 – Fax: 415.896.4568 – email: rainergeissler@comcast.net

Authorization to Release Confidential Information

I, ____ DOB: ____________________
(Name of Patient)

hereby authorize **Rainer Geissler, MA, MFT** to release confidential information obtained during the course of my treatment to

____
(Name and function of the person(s) or entities to which information is to be released)

This Authorization permits the release of the following information:

❑ Any and All Information Necessary ❑ Diagnosis ❑ Treatment Plan
❑ Prognosis ❑ Progress to Date ❑ Clinical Test Results
❑ Dates of Treatment ❑ Patient Records ❑ Summary of Treatment
❑ Other: ____

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

____

____

The recipient may use the information described above solely for the following purpose(s):

____

____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: ___________________________________ ("Expiration Date")

____ Date: __________________________
(Patient Signature or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative