CSC | C. Sloan Consulting
Christopher S. Rigling, Psy.D.,MBA

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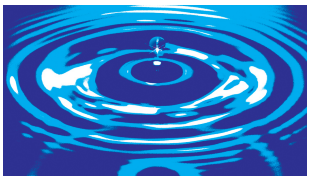

Every Act Creates a Ripple

Authorization to Release Information

I, (name of patient) _____, (hereinafter "Patient") hereby authorize Christopher S. Rigling, Psy.D. (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to Provider's diagnosis of Patient to:

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by the Provider at the above address to be effective.
The disclosure of information and records authorized by the patient is for the following purpose:

The Provider shall not condition treatment upon Patient signing this authorization, and Patient has the right to refuse to sign this form.
Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable law may protect such information

The authorization shall remain valid until: _____.

_____ **Date: _____/_____/_____**

(Patient Signature)