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Authorization for Release of Information

I, _____, hereby authorize Brigitte Lank, Ph.D. to release the clinical records and information pertaining to my mental health history, treatment, and services rendered to _____.

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Dr. Lank unless I request otherwise. I may withdraw this consent at any time. If withdrawn, I understand that Dr. Lank may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I also agree to pay any fees, if applicable, associated with copying, reviewing, and mailing of records.

Signature: _____ Date: _____

Printed Name: _____

Additional Release of Information

Complete to allow your other provider(s) to consult with me, if applicable.

In addition, I authorize _____ to release clinical records and information pertaining to my mental health history, treatment, and services rendered to Dr. Lank.

Signature: _____ Date: _____

Printed Name: _____