Ariati S. Rakic, Ph.D.
Clinical Neuropsychology
CA License PSY 13781

optimalmindsneuropsychology.com
drariatirakic@gmail.com
Fax: (925) 320-7275

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name: _____

I authorize the exchange of information between the following mental health professionals, healthcare providers, agencies, medical facilities, educational institutions or staff, or legal representatives as specified below, for the purposes of coordinating services, patient care and treatment planning, or consultation.

☐ I authorize Ariati S. Rakic, Ph.D. or her representative to release information to:

Name of Provider/Organization_____

Address:_____

Phone Number: _____

☐ I authorize_____

_____

to release information to Ariati S. Rakic, Ph.D. or her representative.

This authorization includes the release of all pertinent psychiatric, educational, medical, and/or legal information, and should be valid for a period of one year, unless otherwise specified.

_____ _____

Signature of Patient or Representative Date