



# SAN FRANCISCO FORENSIC INSTITUTE

*At the Interface of Psychology & Law*

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## Authorization to Release Confidential Information

\_\_\_\_\_  
Holder of Privilege and/or Client (please print) Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

I, the above-named, request and hereby authorize (Name or Organization) \_\_\_\_\_  
to DISCLOSE  and/or RECEIVE  personal information regarding my case to the *San Francisco Forensic  
Institute, Charles A. Flinton, Ph.D., Mark G. Koetting, Ph.D., Cynthia V. Rinker, MFT and staff.*

I understand that the information to be released will include information related to my mental and physical health as well as any court-related information.

The disclosure is for the purpose of consultation and includes but is not limited to the following:

- Medical/psychiatric information, results, diagnosis, evaluation, treatment and discharge.
- Summary /copy of psychosocial/ behavioral history and treatment.
- Summary /copy of psychological/vocational testing.
- Pertinent legal information (Police, Probation, Pretrial Services, Court Orders, etc.).
- Case Conferences/Case Management information.
- Physical examination results.

I understand that the person/organization receiving the above specified information, under Federal regulations, may not disclose this information further unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

This authorization is effective immediately. This consent may be revoked by me at any time unless the information has been released or transmitted prior to the revocation. If not revoked in writing this authorization to exchange information is valid for one year from the date signed below.

\_\_\_\_\_  
Client Signature/Other Person Authorized to Sign Date \_\_\_\_\_

\_\_\_\_\_  
Name and Title of Witness Date \_\_\_\_\_

Contact Information \_\_\_\_\_  
Name and/or Organization Telephone AND fax \_\_\_\_\_

\_\_\_\_\_  
Street Address City/State Zip Code \_\_\_\_\_