AUTHORIZATION TO RELEASE INFORMATION

This form is provided in the event that an exchange of information is needed between Georgi Distefano and third parties during the provision of Psychotherapy services.

I hereby authorize L. Georgi Distefano to release or exchange

☐ All written assessment, evaluation, treatment plan, discharge recommendations and psychotherapy progress records to: Recipient's name and address

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_____

OR

☐ Evaluation and Treatment summary only: Recipient's name and address:

_____

OR

☐ Verbal clinical information regarding assessment, diagnosis, treatment progress, recommendations, and dates of service between: Recipient's name and address:

_____

Client: _____ DOB _____

Purpose of release: _____

This authorization for use or disclosure of medical information is being authorized by me giving L. Georgi Distafano LCSW permission to disclose medical/psychiatric information obtained in the diagnosis and/or treatment of me. This disclosure of medical/psychiatric information complies with the terms of 45 CFR Parts 160 & 164, and the Confidentiality of Medical Information Act of 1981, section 56, et Seq, California Civil Code. Re-disclosure of the information by the recipient is prohibited.

I understand that the medical information to be released may contain information pertaining to my psychiatric, drug and/or alcohol related evaluation and/or treatment, and may also contain educational, psychological and laboratory test results.

I may revoke this authorization at any time by contacting Georgi Distefano, except to the extent action has been taken in reliance upon this consent. If it is not revoked earlier this consent shall terminate without express revocation one year from the date shown below.

Date: _____ Signed: _____

Witness: _____