AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I,_________________________________, hereby authorize__________________________________ to
[Name of Patient] [Name of Provider]
release confidential information and records obtained during the course of my treatment to

____
[Name and Function of the Person(s) or Entities to which information is to be released]

This Authorization permits the release of the following information: Any and All necessary information communicated through all electronic devices, individual and/or teletherapy treatment including but not limited to:

____ Diagnosis	____ Prognosis	____ Patient Records
____ Treatment Plan	____ Progress to Date	____ Summary of Treatment
____ Dates of Treatment	____ Clinical Test Results	____ Drug testing results:
____ Legal violations:	____ Other ____________________	

[Describe Here]

I authorize the release of the information described above for the following purpose(s):

____

____

The recipient may use the information described above solely for the following purpose(s):

____

____

I understand that I have the right to receive a copy of this authorization. I also, understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain in effect until: ______________________________
[Expiration]

Signed by:____ Date: ___________________________
[Patients or Patient's Representative*]

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

____

Respectfully Submitted,

Angela Aiello, Ph.D. Provider of Individual and Teletherapy services
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