AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, ____ hereby authorize Wendi Vecchiarelli, LMFT to release confidential information obtained during the course of my treatment to ______________________________

____.
(Please include full name, address and phone number)

This Authorization permits the release of the following information:

___ Any and All Information Necessary

___ Diagnosis

___ Treatment Plan

___ Prognosis

___ Progress to Date

___ Clinical Test Results

___ Dates of Treatment

___ Patient Records

___ Summary of Treatment

___ Other: ____ ________________________________

____

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

____

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

____

____

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

This Authorization shall remain valid until:________________(“Expiration Date”)

Name: _________________________ Date: _________________ (Patient or Patient’s Representative*)

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

____