

BRUNETTI CONSULTING, PC

Psychological Services

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Release of Information

I Hereby Authorize Brunetti Consulting, PC. to:

- REQUEST FROM RELEASE TO EXCHANGE WITH

(facility name and address)

Regarding the Following Patient:

Patient Name _____ Phone # _____
Other Names _____ Date of Birth _____
Address _____

Records to be Released (check all that apply):

- Consultation Report Recent Progress Notes Discharge Summary School Records
 History and Physical Psych Testing/raw data Verbal exchange Neuroimaging

I also authorize the release of information relating to:

- Psychiatric/Psychological Evaluation/Treatment Alcohol/Drug Abuse Evaluation/Treatment

Purpose of this release:

- Continuing Care Insurance Litigation Personal Use other _____

This authorization expires on the following date _____

If I do not specify any expiration date, this authorization will expire one year from date signed.

Statement of Authorization:

- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Brunetti Consulting, PC. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I understand that once information is released as is specified in this authorization, Brunetti Consulting, PC. and their employees cannot prevent the re-disclosure of that information. I hereby release them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
- I have the right to not sign this form. If I choose not to sign this form, my failure to sign will not impact my treatment.

Signature of Patient/Legally Authorized Representative

Date

Relationship to patient

Reason unable to sign