BRUNETTI CONSULTING, INC.

Psychological Services

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Release of Information

I Hereby Authorize Brunetti Consulting, Inc. 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, Inc. 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, Inc. 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