DAWN IPPOLITI MA, ATR-BC, LCAT
www.art-therapy.com
917.374.7977

AUTHORIZATION FOR RELEASE OF TREATMENT INFORMATION

I, (client name, parent/guardian)_____, hereby request and authorize Dawn Ippoliti_____ to release the following information:

❏ Intake, assessment(s), progress reports, summaries, and treatment recommendation
❏ Photographs, copies and/or facsimiles or artwork
❏ Specific information as follows:_____
_____

from the records of _____
(client name)

TO BE RELEASED TO:

_____
(Name)

_____
(Name of Agency or Practitioner)

_____
(Street Address)

_____
(City, State, ZIP)

I give permission for this information to be used for the following purpose: _____

This information appears in my
_____records.
(own, child's, client's)

This authorization expires on _____ (if not specified, authorization expires one year from the date of consent.)

_____
Client Signature Date

_____
Parent/Guardian Signature