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Authorization for Release of Information

This form when completed and signed by you authorizes me to release protected information from your/ your child's clinical record to the person you designate for the purposes of coordination of care/ diagnostic purposes/ treatment planning.

I authorize Dr. Ronald Naso to release information regarding:

Name _____ DOB _____

This information should only be released to:

Name _____

Address _____ Contact No. _____

Name _____

Address _____ Contact No. _____

Name _____

Address _____ Contact No. _____

This authorization shall remain in effect for one year from the date signed. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that the designated has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my (my child's) psychologist generally may not condition psychological services upon my signing an authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient (or Parent if patient is a minor) _____ Date _____

(Signature of 2nd Parent if patient is a minor) _____ Date _____