ROSARIO ORTIGAO, M.A., LICENSED MENTAL HEALTH COUNSELOR

407-375-1301

Authorization to Release/Obtain Information

I request and authorize Rosario Ortigao, LMHC, to RELEASE to and/or OBTAIN from (circle both, if ok):

Name:
_____

Full address:
_____

_____
___

Telephone number(s): _____ Email address:
_____

Email address:
_____

Regarding (Client's) Date of Birth:
_____

Name:
_____

If a child, both parents' names:
_____

Full address(es):
_____

_____
_____

I authorize the above agency/office/person(s) to release/obtain the following (YOUR INITIALS, please):

___Clinical/Psychotherapy Notes* ___ Assessment and Recommendations ___ Diagnosis

___ Social History/Intake ___ Progress Reports ___ Change In Condition Or Status

___ Discharge Summary ___ Medical History ___ Alcohol, Drugs, Addictions History

___ Psychological Tests ___ HIV, HBV, TB Status ___ Other:
_____

___ Clinical/Psychotherapy Notes *from (this date) _____ until (this date) _____

The above information may either be released via verbal (telephone) or written information for the

specific purpose
of_____

I hold Rosario Ortigao harmless regarding the use of information authorized for release of exchange.

I understand that this form is not required as a condition for treatment and that it may be revoked

by me in writing at any time, except to the extent that action has already been taken. In the absence

of revocation, this authorization will expire when treatment ends (client stopped coming; or

mutually agreed upon treatment completion; or within a year from the date of my signature).

This authorization is for records protected under the privacy regulations of HIPAA (The Health

Insurance Portability and Accountability Act) and by Federal Confidentiality rules (42 CRF Part 2).

A copy of this Authorization is as authentic as the original signed Authorization to Release/Obtain

Information.

I fully understand what I just read and acknowledge that all parties above, including myself, will

retain a copy of this Authorization.

Client Signature: _____Witness: _____

Parent or Legal Guardian Signature: _____Date: _____