ROSARIO ORTIGAO, M.A., L.M.H.C.

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Authorization to Release/Obtain Information

Request and Authorize: Rosario Ortigao to RELEASE to and/or OBTAIN from (Please circle one): _____

_____

_____

Regarding (Patient): _____ DOB:_____

Address: _____

_____

I authorize the above named agency, persons or office to release/obtain:

_____ Diagnosis
_____ Social History/Intake
_____ Progress Report
_____ Psychological
_____ Alcohol, drug or Chemical use/history
_____ Change in condition or status
_____ Clinical/Psychotherapy notes
_____ Medical History
_____ Discharge Summary
_____ Assesment & Recommendations
_____ HIV, HBV, or TB status
_____ Clinical/Psychotherapy Notes from _____ to _____ (insert dates of notes to be released/obtained)
_____ Other: _____

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

I hold Rosario Ortigao harmless in regard to 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 one 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. An original will be retained in my medical records. I fully understand what I just read and acknowledge that I have received a copy of the "Authorization to Release/Obtain Information". _____ (Initials)

Patient signature: _____ Witness: _____
Parent or Legal Guardian Signature: _____ Date: _____