SDE

Susan E. D'Esposito, Ph.D.

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AUTHORIZATION TO RELEASE & RECEIVE INFORMATION

Client's Name:_____ Date of Birth: _____

I request and authorize: Susan E. D'Esposito, PhD

To release and receive information regarding the Client named above

To/From: _____
(name of person or organization giving/receiving information)

Address: _____

City: _____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

This request and authorization apply to:

☐ All treatment information

☐ Information relating to the following treatment, condition, or dates: _____
_____
_____
_____

☐ Other (please specify): _____
_____
_____
_____
_____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that the provider of the information disclosed cannot guarantee that the recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.

Client or Parent Signature: _____ Date Signed:_____

Print Name: _____

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED.