

**Maria Gianunzio, Ph.D.**

1805 N. Mill Street, Suite B

Naperville, IL 60563

**AUTHORIZATION TO RELEASE INFORMATION**

Patient: \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

I/We authorize and request Dr. Kimberly A. Lemke, P.C., Mary Englund Psy.D.,LLC & Maria Gianunzio, Ph.D. to release confidential professional information including personal, psychiatric, medical, laboratory, psychological testing data and interpretation, social, educational, substance abuse, clinical information, opinions, and/or any other information regarding his/her contacts with myself to:

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

I/We also authorize and request the same above named person(s) to release any and/or said information to Dr. Kimberly A. Lemke, P.C., Mary Englund Psy.D.,LLC & Maria Gianunzio, Ph.D.

I understand that my refusal to consent to release the information specified above will prevent disclosure of such materials to the person/facilities named herein, with the potential consequence of reduced accuracy and completeness of my care.

The release is valid through \_\_\_\_/\_\_\_\_/\_\_\_\_ unless dated as follows \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Patient Signature (if age 12 or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Signature of Witness

\*\*If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.