Health and Therapy for Women

Medical Release of Information

By signing this form, you are giving consent for the provider to discuss your treatment with another party. The provider has the right to decline talking to a particular party about your treatment and medical care. The provider will only discuss pertinent medical details about your treatment. In addition, my provider Lisa M. Petrongelli, PsyD, MSN, APRN-BC, FPA at Health and Therapy for Women can share my medical records with the below designated person.

I authorize my provider at Health and Therapy for Women to contact the below providers, request previous medical records (if required), and discuss my health and psychotherapy care.

I am aware that my provider has an obligation to notify my contact if I am threatening to harm myself or others during our appointment, on the phone, or email. I also agree that my provider will not contact a third party if he/she does not feel it is relevant to my care or the scope of practice and treatment.

Provider(s) Name and Contact information:

1._____
Address :_____
Contact number:_____

2._____
Address :_____
Contact number:_____

3._____
Address :_____
Contact number:_____

4._____
Address :_____
Contact number:_____

_____

Client Name_____

Signature _____

Relationship to client _____Date_____