Amy K. Bach DiLello, Ph.D.

154 Waterman Street

Providence, RI 02906

(401) 374-6893

**AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Amy K. Bach DiLello, Ph.D.

to obtain from/release to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information pertaining to my diagnosis and treatment for purposes of evaluation, treatment or billing.

I have been informed that under Rhode Island state law, communications between a patient and his/her psychologist are privileged and may not be disclosed by the psychologist unless the patient consents, barring the instance in which I pose a threat to myself or to others. I have also been informed that patient records maintained by a psychologist may not be disclosed to third parties except with the patient’s consent or through legal process.

This authorization is only for the limited purpose of releasing information to and discussing my case with these individuals or professional groups for purposes of evaluation, treatment, or billing. It shall not be deemed a waiver of any privileged communications or confidential information.

I further release Dr. Bach DiLello of any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law. This authorization shall remain in effect until revoked by me in writing.

I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records to those persons/agencies named above.

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Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name Witness