Ψ Clinical Psychology

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CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION
between John A. DeNinno, Ph.D. and another person/facility/insurance carriers

By my signature below,

I _____, authorize John A. DeNinno, Ph.D. and

person or facility:_____
address:_____

to exchange any and all information or professional assessments which they may have or acquire about me (whether that information be medical, psychiatric, psychological or historical in nature) for the purpose of coordinating my care or making decisions regarding my managed care benefit.

For as long as this consent is in effect, I also allow John A. DeNinno, Ph.D. and my health insurance carriers to exchange any information reasonably necessary to determine the nature and extent of my insurance benefit regarding treatment I receive.

This consent expires 90 days following the date of my signature below. I, or my legal representative, may extend or revoke this consent at any time; however, such an extension or revocation must be dated and in writing. I acknowledge that the exchange of information prior to any such delivery of a revocation to John A. DeNinno, Ph.D. will not constitute a breach of my rights to confidentiality.

Client Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____