BMP
Balanced Mind Psychology

Authorization to Receive and Release Information

Name of patient: _____

Patient's date of birth: _____ Patient's phone number: _____

Patient's address: _____

I, _____, authorize Dr. Michael Costa to discuss my, or my child's, information and treatment (includes any pertinent psychological or medical background information and current issues) with the following parties:

Name: _____ Agency: _____

Phone number: _____ E-mail address: _____

Address: _____

Name: _____ Agency: _____

Phone number: _____ E-mail address: _____

Address: _____

I understand this authorization will expire at the termination of treatment or at any time prior upon written request. I hereby consent that this communication can take place via the following methods:

_____telephone _____e-mail _____mail _____fax _____in person

I understand that e-mail is not a confidential method of communication and that there is a risk that email communications may be intercepted by a third party or may be transmitted to unintended parties. I am aware that Dr. Michael Costa will take all necessary measures to avoid using identifying information in email communications.

Signature of patient:_____ Date: _____

If minor, signature of parent/guardian: _____

Relationship to patient: _____ Date: _____

Signature of clinician: _____ Date: _____