AUTHORIZATION TO RELEASE RECORDS FORM

I understand that my records may contain information related to my behavioral or mental health services, treatment for drug or alcohol abuse, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that any use of disclosure already made cannot be undone, and any disclosure of information carries the potential of unauthorized redisclosure. I acknowledge that I may revoke this authorization in writing at any time and at that time, my authorization of the information described above may no longer be used or disclosed for the purpose described in this written authorization. To revoke this authorization, I must do so in writing. Authorization of this disclosure is completely voluntary. Dr. Federici has answered any questions that I may have had concerning this matter. I acknowledge that I am familiar with the risk involved in releasing confidential matter, and I fully understand the terms and conditions of this authorization. I understand that I do not have to sign this form, and

I Authorize Dr. Federici to Release the Following Information:

- ☐ Diagnosis
- ☐ Summary of Psychological History
- ☐ Results of Tests
- ☐ Other _____

To the Following: _____

Address : _____

The above requested private mental health information is requested for: (*be as specific as possible*)

_____

_____

Dates of Treatment this Release Covers _____

This Release Shall Expire *(date)*_____ or _____ after my last session.

(A minors signature is required for patients 14 and older)

_____	_____	_____
Signature of Patient	**Print Name**	**Date**
_____	_____	_____
Signature & Relation if Not Patient	**Print Name**	**Date**