AUTHORIZATION TO VERBALLY DISCUSS CONFIDENTIAL INFORMATION

Patient Name: ___________________________________ Date of Birth: ____________

I give permission to Dr. Richard Federici, LLC (Dr. Federici) to VERBALLY discuss the following:
(check all that apply):

- ☐ Appointments - ie. Scheduling, Cancellation
- ☐ Release and Exchange Clinical Information
- ☐ Test Results
- ☐ Entire Record at Dr. Federici's Discretion
- ☐ Other ____

Dr. Federici has my permission to discuss the above with:

NAME	PHONE	RELATIONSHIP

The above is to be disclosed for:

- ☐ Evaluation or Diagnosis
- ☐ Continuity of Care/ Coordination of Services
- ☐ Other ____

This Authorization shall be effective until *(check one):*

- ☐ All Past, Present, and Future Periods
- ☐ All Past, Present and until _____ Weeks after My Last Therapy Session
- ☐ Date or Event: *(Please Specify)* ____________________________
- ☐ When I Cancel it in Writing

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 may cancel this permission at any time by informing Dr. Federici in writing, but that cancelling it will not affect any information that has already been released.

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

____________________________________ ________________
Signature of Patient Date

_____________________________________ _________________________ __________
Signature and Relation, if not Patient Print Name Date