Consent to Release Confidential Information to Another (third) Party

1. I, ____ (print your name and date of birth), am completing this form to allow the use and sharing of my protected health information.

2. I authorize Arinn Testa, Psy.D., to disclose my psychotherapy treatment records (which may include admission and discharge summaries, psychological evaluations, reports, assessments, treatment notes, progress notes, psychotherapy attendance records).

3. Dates of care for which the information will be disclosed include:

   From _beginning of this treatment episode_ to _present time_

   Or specify the time period for which you are giving Dr. Testa the permission to release your records:

   From ____________ to _______________ and

4. I authorize Dr. Arinn Testa to disclose the above noted information to this person &/or organization:
   (list below the person(s) and/or the organization(s) that will be receiving your records from Dr. Testa; please, be sure to provide complete address and contact information for this "third" party)

   ____
   ____
   Street: ________________________ City: ______________ Zip Code: ______________
   Phone: ____________________ Fax (if known): ______________________________

5. The information will be used/disclosed for the following purposes (e.g. continuity of care, etc)

   ____
   ____

6. I understand and agree that this Authorization will be valid for one year from this date unless specified otherwise here: ____
   ____
   [Note a date or event upon which this Authorization expires. For example, you may choose to have this authorization expire 1 month from today or 6 months from today; or you may request that this authorization expire upon such event as the termination of therapy with Dr. Testa, in which case write down in the space above "termination of therapy with Dr. Testa."]

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to Dr. Testa. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 2, above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

11. I understand and agree that there may be administrative charges associated with the use or disclosure of my health information. The relevant financial arrangement has been explained to me and I understand and accept it.

12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

____ ______________

Signature of client or his or her personal representative Date

13. I (the client) acknowledge that I received a copy of this completed form: _______ (initials). I (the client), have declined the copy of this completed form: _______ (initials)

14. I, Arinn Testa, Psy.D., have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

______________________________ ______________________________ ________________

Signature of professional Printed name of professional Date