Cynthia L. Sarris, LCSW, LLC | Dana M. Pelliccia, LPC | Andrea C. Basel, LCSW | Emily Samander, LMSW

Authorization for disclosure/Obtain/Access Information

Date ____________________

Patient ____ **Date of Birth** ____________________
Last Name First Name

I hereby authorize Cynthia Sarris/ Dana Pelliccio/ Andrea Basel/ Emily Samander to: (check one or both)

☐ Disclose- share information about me and my medical records

☐ Obtain- receive information about me and my medical records

To/From: Name and Address of third-party organization or individual:

Name ____ **Phone** ____________________

Address ____ **City** ______________ **Zip** ______________

The information that is obtained/disclosed/accessed might include my service and/or treatment information related to my diagnosis or treatment of my psychiatric condition. The information may be obtained/disclosed in verbal, written and/or electronic format.

THE PURPOSE of this disclosure is/are as follows:

☐ Treatment Planning ☐ Court Related or Legal ☐ At request of individual

☐ Discharge and Referral ☐ Disability Determination ☐ Other (specify)

Under the applicable law the information disclosed under this authorization may be subject to further disclosure.

I may revoke this authorization in writing at any time.
I may request a copy of this information to be used or disclosed
If the client is under the age of 18, this document must be signed by a parent or guardian.
This authorization shall expire on ____________or 6 months after date of signature

By signing below, I acknowledge that I have read and understand this authorization. My signature below serves as attestation to the fact that I am the client, or I am the legal guardian of the child whose health information is being disclosed.

Signature of Client ____ **Date** ____________________

Signature of Guardian ____ **Date** ____________________

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