

DR. GREGG A. PIZZI & ASSOCIATES, P.A.

Authorization for Release of Information

Client Name: _____ Account # _____

I, _____, authorize the office of Dr. Gregg A. Pizzi & Associates, P.A.

to **release to** and **receive from** the following persons or agencies, the information indicated below:

Name	Address	City	State	Zip
Organization	Telephone	E-mail (if permission to use e-mail is given)		

- | | |
|---|--|
| <input type="checkbox"/> Academic Testing Results | <input type="checkbox"/> Psychological Testing Results |
| <input type="checkbox"/> Attendance Only | <input type="checkbox"/> Service Plans |
| <input type="checkbox"/> Behavior Programs | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Case Notes | <input type="checkbox"/> Substance Dependency Assessment |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Summary / Discharge Reports |
| <input type="checkbox"/> Intelligence Testing Results | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Medical Reports | <input type="checkbox"/> Vocational Testing Results |
| <input type="checkbox"/> Personality Profiles | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Psychological Reports | |

The above information will be used for the following purposes:

- Planning Appropriate Treatment or Program
- Continuing Appropriate Treatment or Program
- Determining Eligibility for Benefits or Program
- Case Review
- Updating Files
- Other (specify) _____

This Consent shall expire (unless otherwise provided by state law):

_____ 90 days after termination of treatment; or
_____ Other (Describe): _____

I understand that my records may be protected under HIPAA and, if so, can not be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to this provider.

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____
(if client is unable to sign)

Signature of Person Informing _____ Date _____
Client of Rights