Dr. Cristina A Scatigno
PsyD, PSYCHOLOGIST
Anxiety Specialist for children, teens, adults.

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I, _____,
hereby authorize Dr. Cristina Scatigno, PsyD. and (Name, phone and fax number, email address)
_____
to exchange information regarding the mental health treatment of
_____.

Type of information to be disclosed: (check appropriate below)	**The purpose of the disclosure :**
☐ Diagnosis	☐ Ongoing treatment
☐ Evaluation/ Psychological Testing	☐ Continuity of Care
☐ Treatment/ therapy	☐ Coordination of Care
☐ Clinical Impressions	☐ Consultation
☐ Treatment Goals	☐ Transfer
☐ Recommendations	
☐ Discharge plan	
☐ Hospital/ Medical records	

This consent is in effect for one year. I understand that I may revoke this authorization, in writing, at any time. I release all parties stated here, from any liability resulting from the release of information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state of confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential except in matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____

Date **Signature of Client or personal representative**

Federal regulations prohibit the recipient of this information from making any further disclosures of this information.