Authorization for Release of Information Form

This form when completed and signed by you, authorizes me to release protected information from your child's clinical record to the person/institution you designate.

I authorize Brian Razzino, Ph.D., PC and Associates_________________________ to release

____

This information should only be released to (name and address of person to whom the information is to be released)

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I also authorize _________________________ and/or his or her administrative and clinical staff (cross out if not applicable)_________________________ to release_________________________ to Brian Razzino, Ph.D.

I am requesting my psychologist to release this information for the following reasons:

____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

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You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist Brian Razzino, Ph.D. generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_________________________   _______________

Signature of Parent   Date