

## AUTHORIZATION TO RELEASE INFORMATION

Client Name: \_\_\_\_\_ Telephone (     ) \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Authorization for Lisa Saponaro PhD, Inc and the following identified individuals/organizations to use, disclose, and/or exchange my protected health information:

\_\_\_\_\_ Person/Organization: \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Address: \_\_\_\_\_ Fax (     ) \_\_\_\_\_

Information Requested: \_\_\_\_\_

Purpose: \_\_\_\_\_

\_\_\_\_\_ Person/Organization: \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Address: \_\_\_\_\_ Fax (     ) \_\_\_\_\_

Information Requested: \_\_\_\_\_

Purpose: \_\_\_\_\_

I may revoke this consent at anytime by notifying IN WRITING, except to the extent that the provider has taken action and reliance on this consent. Once the uses and disclosure have been made pursuant to this authorization, they may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws. Dr. Saponaro will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent provision of health care is solely for the purpose of creating protected health care information for disclosure to a third party on provision of an authorization for disclosure to such a third party.

I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure or the requested information will result in direct or indirect remuneration to the provider from a third party, a statement referencing such remuneration will exist in this authorization.

I understand that I may receive a copy of this authorization, upon request.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Personal Representative of the Patient \_\_\_\_\_

Description of Representatives Authority to act on behalf of the Patient \_\_\_\_\_