Authorization to Release Protected Health Information

I authorize Tina DeMattia, Licensed Marriage Family Therapist, to release Protected Health Information about my therapy, including the times, dates, and types of psychotherapy sessions; summaries of my symptoms, diagnosis, and treatment plan; and summaries of my prognosis and progress to date. This does not include the therapist's notes on my sessions.

This information may be released to:

_____

_____

_____

(Name and address of person to whom the information is to be released)

This information is being released for the following reasons:

_____

("at the request of the individual" is all that is required if you do not desire to state a specific purpose)

This authorization shall remain in effect until _____/_____/_____

Client Rights: You have a right to inspect the contents of your client file and the information released, and if you disagree with the file contents, to submit an Amendment to your records.

Revocation of Consent: You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address with both your signature and that of a witness. However, your revocation will not impact information already released, or release of some information to insurance companies with the legal right to contest a claim.

This Authorization is governed by applicable state and federal laws. Such laws prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes re-disclosure.

_____

Signature of Client

_____

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

_____ _____

Signature of Representative Relationship to Client

_____

Date

Tina DeMattia, MA, Marriage Family Therapist
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