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Request/Authorization to Release Confidential Records and Information

I _____, hereby authorize the following person(s) to exchange information with Melissa Pinnetti, MSW, LICSW:

Person or facility: _____

Phone: _____

Address: _____

_____

Regarding records about _____, born on, _____,
Client's Name DOB

For the following purpose(s):
-Further mental health evaluation, treatment, or care
-Treatment Planning
-Other: _____

The information to be disclosed is marked by an X in the boxes below:
__ Intake and discharge summaries __ Medical history and evaluation(s)
__Mental Health evaluations __ Developmental and /or social history
__ Educational records __ Progress Notes, and treatment or closing summary
__ Other: _____

I have had explained to me and fully understand this request/authorization to release records an information, including the nature of the records, their contents and the consequences and implications of their release. This request is voluntary on my part. I understand that I may take back this consent t any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes above.

_____ _____ _____
Signature of Client/Guardian Printed Name Date