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East Valley Counseling Associates

Authorization to Release or Request Personal and Confidential information

I,_____, hereby authorize and consent Dr. Daniel Christiano, Ph.D. and/or Dr. Stacy E. LaMorgese, Psy.D., of East Valley Counseling Associates, located at 4115 E. Valley Auto Drive, Ste. 208, Mesa, AZ 85206 to release or request the personal and confidential, psychiatric, psychological, medical, therapeutic, and/or academic/educational information (written and/or oral) to the individual or institution identified below.

_____

(Provider Name and Agency)

_____ _____

(Phone) (Fax number or Email Address)

_____

(Address/City/State/Zip Code)

RE: The continuing care of _____ _____

(Client/Patient Name) (Date of Birth)

_____ _____

(Address/City/State/Zip Code) (Phone)

I understand that my records are protected under various confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws. I certify that this consent and release has been made freely, voluntarily and the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it.

This authorization expires one year from the date of signature. _____ (initial)

A photocopy of this authorization is as authentic as the original. _____ (initial)

To the party receiving this information, this information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

_____ _____

Client/Patient Signature Date

_____ _____

Parent/Gaurdian Signature Date

_____ _____

Signature of Witness Date