Request/Authorization to Release Confidential Records and Information

Client Name: _______________________________ Date of Birth: _________

I, (print name)_____________________________, hereby authorize Katharine Ottone, LPC:

☐ To release to
☐ To obtain from

Name:_________________________________
Address: ______________________________
City, State, Zip: _________________________
Phone: _______________

The information released may include:

☐ Social History
☐ Treatment Recommendations
☐ Psychiatric Records
☐ Academic Testing
☐ Progress Notes
☐ Attendance
☐ Medical Records
☐ Verbal Exchange
☐ Treatment Plan
☐ Psychological Testing
☐ Discharge Summary
☐ Summary of Treatment
☐ Other: ____

I understand that such disclosure will be made for the following purpose(s):

☐ Continuity of Care
☐ To provide information to person(s)
☐ Insurance Verification
☐ Treatment Planning/Evaluation
☐ Educational Purposes
☐ Other: _________________________

I understand the above information may include health care information relating to testing, diagnosis, and/or the treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric/mental health disorders, or drug and/or alcohol use. I understand that the information disclosed may be subject to re-disclosure by the recipient and that the information may no longer be protected by HIPPA privacy regulations.

This authorization is subject to revocation in writing only by the undersigned. If not earlier revoked, this consent shall expire one (1) year from the date of signature.

If I am signing as a parent/guardian of a minor child, I further understand that the record released may contain references to me or family.

Client Signature if Over 18: ____________________________________ Date: _______
Parent/Guardian Signature of Minor Client:________________________ Date: _______
Witness: Katharine Ottone, LPC __________________________________ Date: _______
☐ Copy provided to client or parent/guardian

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertrains, as as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A photocopy of facsimile reproduction of this authorization may be used in lieu of the original.

Katharine Ottone Therapy, PLLC and Katharine Ottone, LPC is hereby released from all liability arising out of, or in any way incidental to, producing records or providing information pursuant to this authorization.