Alexandra M. Chiara, Ph.D.
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Authorization to Release Information

I, ________________________________, the undersigned, give permission to **Alexandra Chiara, Ph.D.** to release and provide to:

Name ____

Address ____

Phone Number ____

The following information (check all that apply)

☐ Attendance

☐ Diagnostic Information

☐ Treatment Plan

☐ Information relevant to coordinating care

☐ Details regarding treatment termination

☐ Other (please explain in detail) ____

____

I understand that that this release is valid for the extent of treatment unless revoked in writing.

I further understand that I may revoke this authorization at any time in writing.

If you wish this release to be valid for a shorter term, please indicate the date it shall expire:

____

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

____________________________________ ________________

Signature Date