Jennifer Novello LMSW ACSW
child, adolescent, & adult psychotherapy

Authorization for the Release of Confidential Information with Patient's Physician

Date: _____

Dear Dr. _____,

It is my recommendation to my clients that they make their Primary Care Physician aware that they are currently in counseling. This allows for coordination of services. Please contact me if you would like to discuss this patient's case.

Sincerely,

Jennifer Novello, LMSW, ACSW
4572 South Hagadorn, Suite 2B
East Lansing, Michigan 48823
Phone: 517-999-9005 Fax: 517-798-5668
jennifer@jennifernovello.com

Patient Name: _____

Address: _____

Date of Birth: _____ Phone Numbers: _____

I hereby authorize Jennifer Novello, LMSW, ACSW, PLLC to:

- ❑ DISCLOSE CONFIDENTIAL INFORMATION WITH THE FOLLOWING PARTY
- ❑ OBTAIN CONFIDENTIAL INFORMATION FROM THE FOLLOWING PARTY

_____
Name of Physician / Practice

_____
Address

_____
Phone / Fax Number

I understand that this authorization shall remain in effect for one year from the date below, unless otherwise stated. I understand that I may revoke this authorization at any time by written notice to Jennifer Novello, LMSW, ACSW.

_____
Patient/Parent/Legal Guardian Signature Date

_____
Witness Date