Jennifer Novello LMSW ACSW
child, adolescent, & adult psychotherapy

Authorization for the Release of Confidential Information

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

_____
Person/Entity authorized to receive or disclose this information

_____
Address

_____
Phone / Fax Number

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

- ❑ Assessment
- ❑ Diagnosis
- ❑ Treatment Plan/Summary
- ❑ Progress Notes
- ❑ Clinical Impressions
- ❑ Progress in Treatment
- ❑ Medication Management Information
- ❑ Medical Information
- ❑ Educational Information
- ❑ Continuing Care Plan
- ❑ Other: _____

PURPOSE OF THIS DISCLOSURE:

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services.

If other purpose, please specify: _____

STATEMENTS OF UNDERSTANDING:

1. I understand that this form has been prepared by Jennifer Novello LMSW, ACSW, PLLC in accordance with Public Act 56, and is in compliance with title 42 of the Code of Federal Regulations, Part II governing release of client information.
2. I understand that unless I have specifically requested in writing that the disclosure be made in a certain format, Jennifer Novello LMSW, ACSW, PLLC reserves the right to disclose information as permitted by this authorization in any manner that deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
3. I understand that if a person or entity that receives the above information is not a health care professional or other provider or professional covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
4. I understand that I may refuse to sign this document, and that doing so will *not* affect my ability to obtain services from Jennifer Novello, LMSW, ACSW, PLLC, except in very limited circumstances.
5. I understand that this consent is subject to revocation at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred.
6. I understand that this authorization will expire in **1 (one) year** of the date signed below *unless otherwise noted here*: _____

_____
Patient/Parent/Legal Guardian Signature Date

_____
Witness Date

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