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AUTHORIZATION TO DISCLOSE PSYCHOLOGICAL / PSYCHIATRIC INFORMATION

If you sign this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is being signed voluntarily and you may change your mind at any time.

I give permission for Donna Gugliotta, M.S., L.M.F.T. to exchange information with the following persons or agencies:

NAME PHONE/FAX

1.____

2.____

3.____

regarding contact with me or my minor child.

____

NAME OF PATIENT AND DATE OF BIRTH ___/___/______

____

Signature of Patient or Parent (if minor) Date

Limitations

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