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To facilitate the coordination of your care, I may need to discuss your health information with an individual that you designate, or acquire health information from a third party. Before I am able to do so, you will need to complete and sign the enclosed "Authorization for Release of Information" form. Please complete, sign and date the form below.

Authorization for Release of Information

Name: _____

Date of Birth: _____

Address: Street: _____ State: _____ Zip: _____

- I understand that this authorization is voluntary.
- I understand that my Health Information may be protected by Federal Rules of Privacy of Individually Identifiable Health Information, the Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records and/or State laws.
- I understand that my Health Information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the information may be no longer protected by the Federal Privacy regulations.
- I understand that my Health Information may contain information created by other persons or entities including health care providers and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transited disease information.
- I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.
- I understand that I may revoke this authorization at any time by notifying Diane Grimaldi, DNP, PMHCNS, BC in writing. However the revocation will not have an effect on any actions taken by Dr. Grimaldi before the revocation was received.

The purpose of this authorization is to facilitate the appropriate management of my treatment sand services. Regarding my individually identifiable health information, I authorize Dr. Grimaldi to receive and/or disclose health information to the following person (s) or organization (s):

1. Name: _____

Address: _____

Phone number: _____

2. Name: _____

Address: _____

Phone number: _____

3. Name: _____

Address: _____

Phone number: _____

All dates of records will be disclosed unless you indicate otherwise below:
From 01/01/2016 to today (see date below).

I understand that this authorization will expire one year from today's date (the date of the signature below). You have the option to list a date or event for which you wish the Authorization to expire.

Signature: _____

Date: _____