VENDETTI
WELLNESS GROUP PC
Tel: 508.589.5333 Fax: 774.250.2693

Authorization and Release of Information

Client Information:

- Full Name: _____ Date of Birth: _____
- Address: _____
- Phone Number: _____

I, the undersigned, authorize Vendetti Wellness Group to:

(__) Release Information to: _____

(__) Obtain Information from: _____

Name of Person/Organization: _____

Address: _____

Phone Number: _____

Fax/Email: _____

Specific Information to be Disclosed:

(__) Assessment/Treatment Summary
(__) Psychological Testing Results
(__) Academic/School Records
(__) Psychiatric Evaluations/Progress Notes
(__) Discharge/Aftercare Plan
(__) Substance Abuse Records

(__) Other: _____

Purpose of Disclosure:

(__) Continuity of Care
(__) Treatment Planning

VENDETTI
WELLNESS GROUP PC
Tel: 508.589.5333 Fax: 774.250.2693

Authorization and Release of Information

(__) Legal Purposes (__) Insurance/Billing

(__) Other: _____

Method of Disclosure:

(__) Written Report (__) Email

(__) Verbal Communication (__) Fax

(__) Other: _____

I understand that:

1. This authorization is voluntary, and I may revoke it in writing at any time, except to the extent that action has been taken based on this authorization.
2. I have the right to inspect and receive a copy of the information being disclosed.
3. Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
4. This authorization expires one year/12 months from the date of signature unless otherwise specified here: _____.

Client Signature: _____ **Date:** _____
Parent/Guardian Signature (if applicable): _____
Relationship to Client: _____