JENNIFER BALLERINI, PSY.D

Helping People Build Better Relationships

RELEASE OF INFORMATION

I hereby authorize Jennifer Ballerini, Psy.D. to receive, use, or release health information and records obtained during the course of treatment for:

Patient Name: _____ Date of Birth: _____

Address: _____

The information is to be disclosed to and/or from the following person or organization:

Person/Organization: _____

Phone: _____ Fax: _____

The purpose of this information release is treatment planning. Specific records may include all dates of service and all or any part of records unless indicated below:

_____

Please acknowledge you understand the following information by initialing below:

_____ I understand that I may refuse to sign this authorization and that my signing is voluntary. I hereby release Jennifer Ballerini, Psy.D. from any liability arising from this authorization.

_____ I authorize the parties listed above to talk by telephone if relevant to the above listed purpose for this release of records.

_____ I can make a written request to stop use or release of information at any time, although I understand that I cannot stop information previously used/disclosed under this authorization.

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including California Confidentiality of Medical Information Act: California Administrative Code, Title 22; California Welfare and Institutions Code 5328; Title 42 of the Code of Federal Regulations; and HIPAA.

_____ _____ _____

PRINTED NAME CLIENT SIGNATURE DATE

_____ _____

JENNIFER BALLERINI, PSY.D. DATE

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