Antone F. Feo, Ph.D. & Associates, Inc.

24500 Center Ridge Road, Suite 120
Westlake, Ohio 44145-5602
(440) 899-1300 Fax (440) 899-0266

CLIENT AUTHORIZATION FOR COLLATERAL INVOLVEMENT IN PSYCHOTHERAPY SESSIONS

I, _____, DOB _____/_____/_____

agree to have _____ participate in my individual psychotherapy session.

I understand that I am the patient of record and am afforded confidentiality protection rights.

By agreeing to have this individual present in this clinical setting, I realize that I am waiving my right to confidentiality. I further understand that he/she is not entitled to any information in my record without my written authorization. Should I release any information from my record to a third party; any identifying information pertaining to him/her will be redacted.

I understand that this information is valid only for a period of 180 days from the date of this authorization.

_____	_____
Released by	Witnessed by
_____	_____
Date	Date

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COLLATERAL AUTHORIZATION FOR INVOLVEMENT IN PSYCHOTHERAPY SESSIONS

I, _____, DOB _____ - _____ - _____

agree to participate in _____ individual psychotherapy sessions. As a participant in this psychotherapy, I realize I may experience some level of anxiety, depression, somatic concern, or other discomfort. If any one of these symptoms presents themselves, I will discuss them with my therapist and/or the presiding therapist at Antone F. Feo, Ph.D. & Associates, Inc.

I understand that I am not the patient of record and am not entitled to any rights and privileges of patients, including a record of my participation and confidentiality. I am considered a collateral to treatment, and am not responsible for payment.

I also understand that any release of information for records can only be done with his/her written authorization since he/she owns the information in the record.

I understand that this information is valid only for a period of 180 days from the date of this authorization.

_____	_____
Released by	Witnessed by
_____	_____
Date	Date