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

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Westlake, Ohio 44145-5602
(440) 899-1300 Fax (440) 899-0266

AUTHORIZATION FOR RELEASE OF INFORMATION

From the records of:
Client Name ______________________________ Date ______________
First Middle Initial Last
Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

I authorize Antone F. Feo, Ph.D. & Assoc., Inc. and/or ____________________ to (check one or both): ___ Release to ___ Obtain From

Facility/Individual ______________________________

Address ______________________________

Phone ____________________ Fax ____________________

I authorize the release of the following information *by* Antone F. Feo, Ph.D. & Assoc., Inc. and/or ____________________:

___ Dates of Treatment ___ Diagnosis ___ Prognosis ___ Treatment Summary

___ Current Treatment Needs ___ Treatment Recommendations ___ Psychological Evaluation Results

___ Other (Specify) ______________________________

AND/OR

I authorize the release of the following information *to* Antone F. Feo, Ph.D. & Assoc., Inc. and/or ____________________:

___ Treatment Needs Identified ___ Treatment Summary/Evaluation ___ Discharge Summary/Evaluations

___ Psychological Testing ___ Medical History

___ Other (Specify) ______________________________

Unless revoked, this Release of Information will expire on: ____________________.

I consent to the release of information designated above. I understand and acknowledge that the information described above may be redisclosed and may no longer be protected under the Health Insurance Portability and Accountability Act of 1996. However, if the above information includes information from records whose confidentiality is protected from disclosure by Ohio and federal law (such as release of HIV test results or diagnoses, substance abuse treatment records and psychiatric records), ORC Section 5122.31, 45 C.F. R. Part 2, and ORC Section 3701.243 prevent the recipients from making any further disclosure of it without specific, written and informed release of the individual to whom in pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

This authorization can be revoked at any time by providing written notice to Antone F. Feo, Ph.D. & Associates, Inc and/or ____________________. I understand that any information released prior to revocation cannot be retrieved and that Antone F. Feo, Ph.D. & Associates, Inc. and/or ____________________ will not be held responsible for such. I hereby release Antone F. Feo, Ph.D. & Associates, Inc. and/or ____________________ from all legal responsibilities or liability that may arise from this act.

A copy of this form has been provided to me.

______________________________ ____________________
Patient/Guardian/or Legal Equivalent Date

______________________________ ____________________
Witness Date