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The Resilience Therapy Group By Robin Pepe, LPC, MA in Counseling, and MA Ed.

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

Name: ______________________________ **Birthdate:** ______________

Address: ____

____

* IF YOU ARE 14 YEARS OR OLDER, OR YOU ARE THE PARENT / GUARDIAN OF THE PATIENT

Email: ______________________________ **Phone:** ______________

Parent/Guardian Name: ______________ **Relationship:** ______________

RELEASE TO / PURPOSE / AUTHORIZATION DATES

Name: ____

Title: ______________ **School/Practice/Facility/Other:** ______________

Address: ______________ **City:** __________ **State:** _____ **Zip:** __________

Email: ______________________________ **Phone:** ______________

Pupose of Release: *I authorize the treating clinician/therapist:* ______________

related to the following: _____ Consistency of Treatment _____ Referral _____ Personal Request of Patient

_____ Billing/Insurance _____ Legal Representation ____ Education ____ Other:(State Reason) ______________

Authorization Dates from: _____ / _____ / _____ **to** _____ / _____ / _____ *, or expires 90 days from signing date if not specified.*

PATIENT RIGHTS AND SIGNATURE

I understand that I have the right to revoke this authorization at any time by sending such written notification to the clinician's office address. My authorization will not be effective to the extent that the clinician has taken action in reliance on my authorization, or, if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claims. I understand that the clinician generally may not condition psychological services upon my signing the authorization unless the services are provided to me for the purpose of creating health information for a third party.
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer

SIGNATURE OF PATIENT *(Or Parent/Guardian if Under 14 Years of Age)*

SIGNATURE: ______________________________ **DATE:** ______________