**Peter Tolisano, Psy.D., LLC**

68 South Main Street, Suite 200

West Hartford, CT 06107

(860) 778-4942

***Form C***

**Authorization to Obtain/Release Information**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization to Release Information:**

I hereby authorize Peter Tolisano, Psy.D. to *release* the following information:

( ) All treatment records

( ) Treatment records specific to the following dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Telephone communication

( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of facility/provider)

**Authorization to Obtain Information**

I hereby authorize Peter Tolisano, Psy.D. to *obtain* the following information:

( ) All treatment records

( ) Treatment records specific to the following dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Telephone communication

( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of facility/provider)

All of the information above is to be shared for the purpose of ( ) continued care or ( ) other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other use of this communication is prohibited.

I understand that the information being released may contain information pertaining to psychiatric, drug, and/or alcohol abuse diagnoses and treatment, and may also contain HIV (AIDS) related information.

I understand that my records are protected by relevant Federal Regulations and Sate Statutes pertaining to drug and alcohol, and psychiatric and HIV information.

I understand that I may withdraw this consent at any time prior to the release of the above information, and understand that withdrawal of this authorization must be done in writing.

This consent is valid ( ) 180 days from this signing ( ) until the end of the treatment episode, or ( ) other duration (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whichever comes first.

**Signature of client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

(Required for all clients 16 years and older with psychiatric diagnosis and all clients 14 years and older with substance abuse diagnosis)

**Signature of parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

(Required of all clients under the age of 18-if guardian or conservator, must supply proof of guardianship of

conservatorship)

**Signature of Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

**Information Released:**