

	Dina Varano, MA, LMHC
	317.590.5351
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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the use or disclosure of my Personal Health Information as described below:

Patient Name: _____ Date of Birth: _____

I hereby give my permission to Dina Varano, LMHC to use, disclose, or exchange my Personal Health Information with this person or organization:

I am authorizing the use, disclosure or exchange of the following Personal Health Information:

- | | |
|--|--|
| <input type="checkbox"/> Dates of Service | <input type="checkbox"/> Psychological Tests |
| <input type="checkbox"/> Initial Evaluation & Diagnostic Impressions | <input type="checkbox"/> School Records |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Medical / Labs |
| <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Clinical Notes | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Verbal Exchanges | <input type="checkbox"/> View Record Only |
| <input type="checkbox"/> Other: _____ | |

This Personal Health Information will be used, disclosed, or exchanged for the following purpose(s):

- I understand that if all items above or Entire Record are checked, the requesting person may received the complete contents of my records, and that Dina Varano, MA, LMHC, cannot under a full release take responsibility for the disclosure of this information. It is assumed that parties to whom information is released will be discrete in disclosing information.
- I understand this authorization is voluntary. I understand that if the person / entity authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.
- I understand this authorization will be valid and in effect for 365 days from the date of signature, unless otherwise specified. I understand and agree that this Authorization will be valid and in effect until: _____
- I understand that I can revoke or cancel this authorization at any time by sending a letter to Dina Varano, MA, LMHC. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Dina Varano, MA, LMHC.
- I affirm that I have had full opportunity to read and consider the contents of this Authorization, that everything in this form which was not clear to me has been explained, and that the contents are consistent with my direction.
- I acknowledge that I have received a copy of this completed form.

Signature of Patient or his/her representative: _____ Date: _____

Printed Name of Patient or his/her representative: _____

Description of personal representative's authority: _____

Witness: _____ Date: _____

Protected health information is personal and may contain sensitive information related to a person's health care. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.