

AUTHORIZATION TO EXCHANGE/RELEASE/RECEIVE INFORMATION

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This authorizes Dr. Michael Messina to exchange information as specified with, release information as specified to, and/or receive information as specified from the following individuals and organizations (include names and contact information):

Regarding: _____

The information so authorized is as follows: Evaluation, Diagnostic, and Treatment Information and Records obtained in the course of psychotherapy treatment.

Other: _____

Any exceptions to the entire aforementioned include: _____

This authorization is in effect until revoked in writing.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable State law may protect such information.

Print Name of Authorizer

Signature of Authorizer

Date