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AUTHORIZATION FOR OBTAINING INFORMATION

I hereby give my consent to Theresa Cerulli, M.D. and Associates (Szifra Birke, LMHC, LMFT, CADAC, Jay Livingston, MA, Rebecca Shafir, MA, CCC, Carol Montgomery, Ph.D.) to exchange any information relating to my/my child's medical, educational, and mental health history among each other and:

1. Name: _____

Address: _____

Phone: _____

2. Name: _____

Address: _____

Phone: _____

You have the right to revoke this authorization in writing at any time by sending written notification. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.

Print Client's Name/DOB

Date

Client/Guardian Signature

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