THERESA CERULLI, M.D.
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AUTHORIZATION FOR OBTAINING INFORMATION

I hereby give my consent to Theresa Cerulli, M.D. and Associates to exchange any information relating to my/my child's medical, educational, and mental health history with:

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 (HIPPA) privacy rule.

______________________ ___________ ______________________

Print Client's Name/DOB Date Client/Guardian Signature

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