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Authorization Form

(This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate).

I authorize my psychotherapist, _____ and/or any of his or her administrative and clinical staff to release _____

This information should only be released to (name, address and phone number of person to whom the information is to be released):

I am requesting my psychotherapist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychotherapist's office address. However, my revocation will not be effective to the extent that my therapist has 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 my psychotherapist generally may not condition psychotherapeutic services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

(If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided).