**Informed Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[Insert Name of Patient/Client], whose Date of Birth is \_\_\_\_\_\_, authorize Amy Pezzotti, MA, LPC, RPT, NCC to disclose to and/or obtain from:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Insert Name of Person or Title of Person or Organization] the following information:

##### Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

\_\_\_\_\_ Assessment

\_\_\_\_\_ Diagnosis

\_\_\_\_\_ Psychosocial Evaluation

\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_ Treatment Plan or Summary

\_\_\_\_\_ Current Treatment Update

\_\_\_\_\_Medication Management Information

\_\_\_\_\_ Presence/Participation in Treatment

\_\_\_\_\_\_ Medical Information

\_\_\_\_\_ Educational Information

\_\_\_\_\_ Discharge/Transfer Summary

\_\_\_\_\_ Continuing Care Plan

\_\_\_\_\_ Progress in Treatment

\_\_\_\_\_ Demographic Information

\_\_\_\_\_\_Psychotherapy Notes

\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EFFECTIVE TIME PERIOD: This authorization is valid until mental health services are terminated with Amy Pezzotti. If services are terminated and further disclosure is requested, a new authorization form must be signed and completed.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice to Amy Pezzotti. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocations or that is otherwise permitted by court order or required by state law. State law requires the reporting of threats of violence or harm to self or others, or child abuse and neglect.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient/Client Date

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 Signature of Parent, Guardian or Personal Representative Date

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 Signature of Staff Witness Date