Christina Ingenito, LCSW
LCS #11949

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME _____ **Date of Birth** _____

With my signature below, I give my authorization for Christina Ingenito, LCSW to discuss/ exchange information relevant to my case with the below–named person for the purpose of psychotherapy assessment, planning and treatment.

Psychotherapist/Physician/Agency: _____

Address: _____

Phone Number: _____

_____ Psychotherapeutic diagnostic and treatment information
_____ Psychological reports & testing results
_____ Medical and diagnostic reports/information
_____ Other _____

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: _____ do not release.

This information will be kept strictly confidential. This authorization is valid from the date of authorization until the client revokes it or upon completion of treatment.

Client Signature _____ Date _____

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