Dr. Beth Giurelli Psy.D. LLC
131 Oak Street
Glastonbury, CT 06033
(860) 918-0960

Authorization to Release Information

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

Your Name _____ Your Date of Birth _____

I authorize my psychologist, Beth Giurelli Psy.D. to contact, release and/or obtain
_x__information related to my psychotherapy
_x__information related to my medical record
___ other:_____

Limitation of release (if any):__Emergency Contact Only_____

Name, phone number and relationship of the emergency contact person this information should be released to/from. This person will be contacted by Dr. Giurelli should an emergency or crisis occur, especially during a Telepsychology session.

_____
_____

I am requesting my psychologist to release this information for the following reasons:

__ for coordination of services between mental health and/or medical providers

_x_ other _____Contact in Emergency or Crisis Situations Only_____

This authorization shall remain in effect until__OPEN__ or until one year from the date this form is signed.
You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient or Legal Guardian