KENNETH A. DE LUCA, PH.D. & ASSOCIATES, INC.

PSYCHOLOGICAL, COUNSELING & EDUCATIONAL SERVICES

AUTHORIZATION FOR RELEASE / DISCLOSURE OF INFORMATION

This form, when completed and signed by you, authorizes your therapist to release protected information from your clinical record to the person you designate. ***You may revoke this consent at any time by providing written notice to the privacy officer; otherwise, this consent will automatically expire twelve months from the date of your signature.***

Patient Name _____ Date of Birth _____

Therapist Name _____

TO DR. DE LUCA & ASSOCIATES

I hereby give permission to _____

_____

_____

to release information regarding the above-named person to Kenneth A. De Luca, Ph.D. & Associates, Inc.

- ☐ Diagnosis/Treatment Plan
- ☐ Psychotherapy Notes
- ☐ Psychological Evaluation
- ☐ Discharge Summary
- ☐ Psychoeducational Testing
- ☐ Social/Family History
- ☐ School Records
- ☐ Medical Records
- ☐ _____

FROM DR. DE LUCA & ASSOCIATES

I hereby give permission to Kenneth A. De Luca, Ph.D. & Associates, Inc., to release information regarding the above-named person to_____

_____

_____

- ☐ Diagnosis/Treatment Plan
- ☐ Psychotherapy Notes
- ☐ Psychological Evaluation
- ☐ Discharge Summary
- ☐ Psychoeducational Testing
- ☐ Social/Family History
- ☐ _____
- ☐ _____

☐ Permission is granted to Kenneth A. De Luca, Ph.D. & Associates, Inc., to communicate with the named person/agency regarding the patient via telephone, questionnaire, and/or manner deemed appropriate.

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

☐ to assist in treatment planning ☐ at the request of the patient

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations.

I understand that once the information is released pursuant to this authorization, Kenneth A. De Luca, Ph.D. & Associates, Inc., any of our employees, or the authorized individual named above, cannot prevent the redisclosure of the information. I hereby release each of them from liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

Signature of Patient _____ Witness _____ Date _____

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

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MAIN OFFICE
35888 CENTER RIDGE ROAD.
SUITE 5
NORTH RIDGEVILLE, OHIO 44039

SHEFFIELD VILLAGE OFFICE
5425 DETROIT ROAD
UNIT 6
SHEFFIELD VILLAGE, OHIO 44054

WESTLAKE OFFICE
2001 CROCKER ROAD
SUITE 600
WESTLAKE, OHIO 44145

ROCKY RIVER OFFICE
20525 CENTER RIDGE ROAD
SUITE 134
ROCKY RIVER, OHIO 44116

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