

Vincent J. Nerviano, Ph.D.

Licensed Psychologist

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Request for and Authorization to Release Protected Health Information, and/or Obtain Records Including Mental Health, Substance Abuse / Addictions, or HIV Information

Client Name: _____ **SS#:** _____ **Date of Birth:** _____

Regarding the above named client, I hereby authorize and request that:

VINCENT J. NERVIANO, PH.D.

**obtain information and/or copies of records from,
and/or release information and/or copies of records to:**

Name of Person and/or Agency: _____

Address: _____

_____ FAX: _____ Phone: _____

These records and/or information are released only for the specific purpose of:

Only the following information and/or records are to be released:

I fully understand this authorization and request to release copies of clinical records or information regarding my treatment. I am aware of the nature of the records, their contents, the consequences and implications of their release. My request is wholly voluntary on my part.

I hereby release the source of these records and Dr. Nerviano from any liability arising from their release. I also authorize the parties above to communicate by phone or FAX on this request and other topics relevant to the above listed purposes for this release of records and/or information.

I understand that I may revoke this consent at any time within one year except to the extent that action based on this consent has been taken. This consent will expire automatically one year from the date of discharge from services, or upon the fulfillment of the above purposes.

[A photocopy or fax of this document can serve for the original.]

(If Parent/Guardian)Name: _____ **Signature:** _____

Witness: _____ **Date:** _____