SantagatiTherapy.com
DonnaSantagati@gmail.com
465 Waverley Oaks Road, 4th Floor Suite 416, Waltham, MA 02452
(773) 860-7770

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ **Date of birth:**_____

Specific information to be released:

☐ **Verbal/ Telephone /Email Update**

☐ **Other *(specify)*** _____

☐ **Discharge Summary/ Summary of Treatment**

From Donna Santagati, Psy.D.
To another person or facility

I hereby authorize Donna Santagati, Psy.D. to release the above information to

Name/Title:_____
Address:_____
Email:_____
Phone: _____

Name/Title:_____
Address: _____
Email:_____
Phone:_____

To Donna Santagati, Psy.D.
From another person or facility

I hereby authorize the following person or facility to release the above information to

Donna Santagati, Psy.D.
Belmont, MA 02478
773-860-7770

From: _____

Name/Title:_____

Address:_____

Email:_____

I understand that this information is not to be re-released to any person or facility except as provided by law. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

_____ _____

Signature of Patient (if 18 or older);
or Parent (if patient is under 18);
or Legal Guardian; or Health Care Agent (circle one)

Signature of Witness

Printed Name of Patient or Authorized Person Date

Printed Name of Witness Date