Diane Colonnello, L.C.S.W., P.A.

(239)275-9665 Fax (239)267-4438

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I , _____, whose date of birth is _____, authorize Diane Colonnello, L.C.S.W. to disclose to and / or obtain from : _____ the following information:

(Client to initial each item disclosed)

____Assessment
____Nursing/medical Information
____Toxicological /Drug Screening
____Educational Information
_____Treatment//Discharge Summary
____Continued Care Plan
____Progress in Treatment
____Demographic Information
____Other

____Diagnosis
___Psychosocial Evaluation
___Psychological Evaluation
____Psychiatric Evaluation
____Treatment plan
____Medication Management Information
_____Presence / Participation in treatment

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning relevant to treatment and when appropriate, coordinate services.

If other purpose please specify: _____

Marketing

- □ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by the [Social Work Organization] in exchange for disclosing the information.$_____

Sale of Information

- □ If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

Research

- □ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research

study is conditioned upon execution of this authorization and individual's ability to opt into each study.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Diane Colonnello at 8192 College Pkwy, Fort Myers, FL. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions

I further understand that Diane Colonnello, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including but not limited to, verbally, in paper format or electronically.

Disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be circumstances_____

I will be given a copy of this authorization for my records.

_____

Signature of patient/client **Date**

_____

Signature of parent, guardian or personal representative **Date**

_____

Signature Witness Date

___ Check her if patient /client refuses to sign authorization.