Dr. Silvi Guerra, LLC
Stress Free CBT
11810 Grand Park Ave Suite 500
North Bethesda, MD 20852
(202) 240-8648

AUTHORIZATION FORM FOR RELEASE OF CLINICAL RECORD

This form when completed and signed, authorizes me to release protected information from your (or your child's) clinical record to the person or institution you designate.

Patient Name: _____ DOB: _____

Address: _____

_____

Phone: _____

I, _____, authorize Dr. Silvi Guerra, LLC to:

_____ Release from my record _____ Receive from my record

_____

(*Provide description of the information that you want disclosed on the line above. Your description should be as specific as possible)*

I am requesting that Dr. Silvi Guerra, LLC release information for the following reasons: ("*at the request of the individual*" is all that is required if you are my patient and you do not desire to state a specific purpose

_____

I understand that Dr. Silvi Guerra, LLC cannot re-disclose information she received from another health care provider if that health care provider requested that the information not be re-disclosed.
This information shall remain in effect for a period of one year from the date below or until _____.

The information is to be released to/released from:

Name: _____ Position: _____
Address: _____
Phone & Fax: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Silvi Guerra, LLC. However, the revocation will not be effective to the extent that action taken in reliance on the authorization of if this authorization was obtained as a condition of obtaining insurance overage and the insurer has a legal right to contest a claim. I understand that Dr. Silvi Guerra, LLC. generally may not condition psychological services upon the signing of an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPPA Privacy Rule.

Patient or Legally Authorized Individual Signature: _____ DATE: _____
Relationship to the patient if signed on behalf of the patient by parent, legal guardian, etc. _____