Diana Marinaro, LCSW
Psychotherapist

Authorization to Release Protected Health Information

I (Name) (Date of Birth) , give permission to Diana

Marinaro, LCSW to disclose and/or obtain information from:

Name:

Address:

For the purpose of Continuity of care.

I may revoke this consent at any time by written request except to the extent where communication has already occurred. This signature will expire when treatment with Diana Marinaro, LCSW has been terminated.

By typing my signature below, I agree to be bound by my electronic signature

Signature:

Date: