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Authorization to Release Confidential Information

I, [Name of Patient] _____

hereby authorize Sona DeLurgio, Psy.D., MFT to release confidential information obtained during the course of my treatment to [name and function of the person(s) or entities to which information is to be released] _____

This Authorization permits the release of the following information:

Any and All Information Necessary
 Diagnosis Treatment Plan Prognosis
 Progress to Date Clinical Test Results Dates of Treatment
 Patient Records Summary of Treatment
 Other _____

I authorize the release of the information described above for the following purpose(s):

The recipient may use the information described above solely for the following purpose(s):

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: _____ (“Expiration Date”)

By: _____ Date: _____
(Patient or Patient’s Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative: _____