Scott J. Romeika, Psy.D.
—
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Authorization to Release Information

Instructions: Complete this form in its entirety and return to Dr. Romeika. To ensure the highest degree of confidentiality, please return the form either in person or to the following encrypted email address: sjromeika@protonmail.com.

Please refer to the **Notices of Privacy Practices** and the **Pennsylvania Notice Form** for details on how your confidential, protected health information is used and disclosed according to legal and ethical standards. Please address any questions you may have to Dr. Romeika at any time.

A. Client Information (you, the client)

Client Name: _____

Birth Date (DD/MM/YYYY): _____/_____/_____

Address: _____

_____

City, ZIP: _____

Phone: (_____) _____ - _____

Email Address: _____ @ _____

B. Recipient Information (to whom you are requesting disclosure of confidential information)

Client Name: _____

Relationship to Client: _____

Address: _____

_____

City, ZIP: _____

Phone: (_____) _____ - _____

Email Address: _____ @ _____

C. Authorization

I, (client name, from Section A) _____, hereby authorize Scott J. Romeika, Psy.D. to release confidential, protected health information to (recipient name, from Section B) _____, for the purpose of _____.
The information that may be released is limited to the following: _____
_____.

I understand that my authorization will remain effective for a period of one (1) year from the date of my signature. I also understand that I may revoke my authorization at any time (except to the extent that action has been taken in reliance thereon) by written, dated communication to Dr. Romeika.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and therefore may no longer be protected by the HIPAA Privacy Rule.

My signature below indicates that I have read and understood the above **Authorization to Release Information** and agree to the disclosure of information as indicated.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____