ALESSANDRA CHIESA, PHD
CARELLA & ASSOCIATES, LLC
P.O. Box 531482
ST. PETERSBURG, FL 33747

(727) 510-3352
FL License # PY6202

Release of Information Authorization Form

This form when completed and signed by you, authorizes Dr. Chiesa to exchange protected information from your child's clinical record to the person you designate.

I authorize psychologist Alessandra Chiesa, PhD and (insert name of person or agency as follows) _____ to exchange information on:

_____ _____
Name of Child **Date of Birth**

This information can only be exchanged between Dr. Chiesa and (name and address of person to whom the information can be exchanged with):

Name of Person or Agency: _____
Address: _____
_____
_____
Tel. Number: _____

I am requesting Dr. Chiesa to consult with _____ for the following reasons: educational planning for

_____ _____
Name of Child **Date of Birth**

This authorization shall remain in effect until a year from the date of signature below.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the mailing address listed above. However, your revocation will not be effective to the extent that Dr. Chiesa takes action in reliance on the authorization.

_____
Name of Client – child to be or evaluated by Dr. Chiesa

_____
Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian* Date

*If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

AMC/amc/1-2014