CATALINA ARBOLEDA, Ph.D
Licensed Psychologist

AUTHORIZATION TO RELEASE/ REQUEST INFORMATION

Client's Name _____. DOB:_____

I hereby authorize Catalina Arboleda, Ph.D., 256 Concord Avenue, Cambridge, MA 02138, to release or request information to or from:

Person or agency Phone

Address

I understand that:

- I have the right to revoke this authorization, in writing. Authorization may be withdrawn except for the following: To the extent that action has already been taken in reliance on this authorization and to the extent that the action was taken as a condition of obtaining insurance coverage (in this case, other laws provide the insurer with the right to contest a claim under the policy).
- Dr. Arboleda may not make psychological services contingent upon my signing this authorization
- Information released on this authorization, if used or disclosed by the recipient, is no longer protected by HIPAA rules
- I understand that this authorization will automatically expire from this date or event: _____ 6 months _____1 year or _____Upon termination of treatment

I have carefully read and understand the above, have had any questions explained to my satisfaction and do herein expressly and voluntarily authorize the communication of the above information to the persons or agencies listed above.

Patient's signature: _____Date: _____
Printed Name: _____

If patient is a minor, or is not competent to give consent, please sign below:

Signature of Legal Representative _____ _____ Date: _____
Relationship to Patient: _____