Peter J. Paterno, MSW, LCSW

Practice in Psychotherapy and Professional Coaching

www.PeterJPaterno.com

342 Grand Ave.
2nd Floor
Englewood,NJ 07631

535 Morris Ave.
1st Floor
Springfield,NJ 07081

201-951-4800(Phone) 973-379-8804 (Fax)

Primary Care Physician
Authorization to Release Information

I,_____, O **authorize** O **do not authorize** information to be released to my primary care physician,_____located at :_____
(Name of Physician)

_____.
(Address, City, State, Zip and Phone #)

The information to be released includes my diagnosis, treatment plan and evaluation and any other relevant information. The purpose of this release is to coordinate treatment services. I understand that I may revoke this authorization at any time except insofar as action has been taken in reliance thereon. At any rate authorization will expire 180 days from signature date or 180 days following last appointment whichever **is later.**

_____ _____
(signature of patient) (Date signed)

_____ _____
(Printed name of patient) (Date of Birth)

_____
(Signature of witness)