Fulton Psychological Group

Alyse Scarmozzino, Psy.D.
AMFT 137887

Supervisor: Jason Mechanick, Psy.D. PSY 24634

Authorization to Release Information

Patient: _____

Address:_____

I hereby authorize Alyse Scarmozzino, Psy.D. to disclose and/or receive from

_____

(name) (phone #)

information pertaining to my (or my child's) psychological services rendered from:

_____ to _____.

Specific information requested includes: _____

_____

This authorization is good until: _____

This authorization allows Dr. Scarmozzino to discuss information described above and can be cancelled at any time in writing by the patient.

Signature: _____ Date: _____
(parent, if patient is a minor)

Dr. Scarmozzino's signature: _____ Date: _____

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