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Release of Information Consent Form

_____ _____
Your name (please print) Birth date

_____ _____
Primary Care Provider (PCP) name PCP phone

_____
PCP address/facility

_____ _____
Therapist (if applicable) Therapist phone

_____
Therapist address/facility

_____ _____
Others involved in your care Phone

_____
Address/facility

I authorize Jeremy SantaCroce, RN/NP, LICSW to release and receive my protected health information from/to:

(Please check one): ___ ALL of the individuals identified above

___ NONE of the individuals identified above

___ ONLY these individuals identified above: _____

for purposes of: ___ Psychiatric/Medical care

___ Other (please specify): _____

This release is valid for 12 months from date of signing OR until: _____

I understand the following conditions apply to this Release of Information Consent Form:

1. Jeremy SantaCroce, RN/NP, LICSW cannot be held liable for how other authorized parties protect, store, use, or disclose information that is provided through this Release of Information.
2. I may revoke this Release of Information Consent Form at any time by providing a written request to Jeremy SantaCroce, RN/NP, LICSW and I will not suffer any undue hardships to treatment to the extent that I understand my treatment may be limited by such revocation.
3. I may decline to sign this Release of Information and not suffer any undue hardship in treatment to the extent that I understand my treatment may be limited by such declination.

_____ _____
Signature Today's date