DEMARLE, INC
Daniel J. DeMarle, Ph.D.
1501 East Avenue, Suite 104, Rochester, NY 14610
(585) 748-2222
ddemarle@yahoo.com

AUTHORIZATION TO RELEASE HEALTHCARE, MENTAL HEALTH, & EDUCATIONAL INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

1. I request and authorize ______________________________________

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to release healthcare and educational information of the patient named above to:

Name: DEMARLE,INC

Address: 206 Melrose St

City: Rochester State: NY Zip Code: 14619

This request and authorization applies to:

☐ Healthcare, mental health, and educational information relating to the his/her evaluation and ongoing treatment:

☐ All healthcare information

☐ Other:

I hereby authorize the periodic use/disclosure of his/her healthcare, mental health, and educational information to DEMARLE, INC as often as necessary

My authorization will expire

☐ When I am no longer receiving services from DEMARLE, INC

☐ One year from this date;

☐ Other

I ALSO AUTORIZE DEMARLE, INC TO SHARE MEDICAL, MENTAL HEALTH, AND/OR EDUCATIONAL INFORMATION WITH THE FOLLOWING INDIVIDUALS

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Patient Signature: I certify that I authorize the use of my health, mental health, and/or educational information

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Signature of Patient or Personal Respresentative Date