EVA ALTOBELLI MD
BOARD CERTIFIED PSYCHIATRIST– NPI# 1790990620

I _____, hereby authorize and give my permission to: Dr. Eva Altobelli
Patient's Name

to release information limited to psychiatric treatment to: _____
Therapist's Name

I understand that my records are protected under the the Federal confidentiality Regulations (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken.

It shall be effective only long enough to answer the purpose for which it is given, and no futher confidential information will be released without the execution for an additional statement of consent.

Valid from _____ to _____

Date of consent _____

Signature of Patient _____

Witness _____

610-348-2340 ❖ EVA@DREVAALTOBELLI.COM ❖ WWW. DREVAALTOBELLI.COM