Viktoryia Biheza Ferretti LMFT, RPT-S
Licensed Psychotherapist
305 735 1188
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Authorization to release healthcare information

_____ _____/_____/_____
Client Name (*Patient or Legal Guardian*) Date of Birth

I request and authorize: _____

To release healthcare information of the patient named above to: Viktoryia Biheza Ferretti LMFT, RPT-S

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition;

_____

Or dates: _____/_____/_____ to _____/_____/_____

☐ All Healthcare Information

☐ Other (*Additional Information*): _____

_____

_____

_____

_____

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above. ☐ YES ☐ NO

_____ _____/_____/_____
Patient signature Date

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED