Emanuel Troiani, Psy.D.
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Authorization for Dr. Emanuel E. Troiani to Release Information to Others

Please use this form if you are giving Dr. Emanuel Troiani (Emanuel Troiani, Psy.D. / Emanuel E. Troiani, Inc.) permission to speak to anyone else regarding your care (spouse, sibling, children, caregiver, etc.). You may also list doctors you would like Dr. Troiani to consult with or doctors you would like to receive a copy of the evaluation report. You do NOT need to fill out this form for the doctors listed on your Patient Information Page (Primary Care Physician or Referring Doctor) unless we contact you with that request.

Patient Name _____ Date of Birth_____

Address _____

_____

Phone _____

I authorize **Emanuel Troiani, Psy.D (Emanuel E. Troiani, Inc.)** to release information to:

Name: _____

Address: _____

_____

PHONE: _____ FAX: _____

for the period of 1 year

This information is limited to: Neuropsychological Evaluation Services

I understand this information is confidential and I have the right to review or revoke this authorization at any time either verbally or in writing.

This authorization is in-compliance with the Pennsylvania Mental Health Procedures Act section 7100.111.3, the Pennsylvania Drug and Alcohol Abuse Control Act and Act 52 of the Pennsylvania State Psychology Board.

I understand the contents of this authorization and I understand my rights.

Patient Signature (if minor, write "minor") _____ Date_____

Parent/Guardian Signature (for minor patient) _____ Date_____