Child and Adult Psychological Services, PLLC

EIN: 82-3773654

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AUTHORIZATION FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)

Name of Individual PHI pertains to: _____

Date of Birth: _____

I hereby authorize Child and Adult Psychological Services, PLLC, and its designated staff to obtain or disclose protected health information about myself and
or my child from the individuals and/ or entities listed below in accordance with the following terms and conditions:

Nature of Information to be disclosed/obtained:_____

___Psychological ___Psychosocial ___Treatment Contacts ___Psychiatric

___Medical ___Educational Other _____

Purpose or need for information:

____ Emergency / Routine Medical or Psychiatric Care ____Treatment Planning

Other: _____

Please check which, if any, apply:

___This information contains records of a licensed mental health facility

___ This information contains records of a federally assisted alcohol or drug abuse treatment program.

Individuals or entities to whom or from whom the information may be obtained or disclosed:

_____

_____

_____

_____

_____

Date or event upon which this authorization will automatically expire unless previously revoked:

____ Upon Final Discharge from the care of Child & Adult Psychological Services, PLLC,

____ 1 year after Final Discharge from the care of Child & Adult Psychological Services, PLLC,

____ Other Specific Date:_____

My signature below indicates that I understand the following:

(1) I may revoke this authorization in writing at any time, except to the extent Child and Adult Psychological Services, PLLC, and its designated staff has taken action in reliance on this authorization.

(2) This authorization is voluntary and Child and Adult Psychological Services, PLLC, and its designated staff may not condition treatment or benefits on my willingness to sign this authorization, except if my treatment is related to research or involves services provided to me solely for the purpose of creating information for disclosure to a third party.

(3) I have a right to a signed copy of this authorization.

(4) Any information obtained or disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by law unless this information is related to HIV/AIDS, consists of the records of a federally assisted substance and alcohol abuse program or consists of records of a New York State-licensed mental health facility, in which case the information may be re-disclosed only in accordance with applicable laws governing such information or records.

I have read and fully understand this authorization form. By signing below, I authorize Child and Adult Psychological Services, PLLC, and its designated staff to obtain and/or disclose my and /or my child's protected health information consistent with the terms of this authorization.

_____

Name of Individual/Parent /Legal Guardian

_____ _____

Signature of Individual/Parent /Legal Guardian Date

_____ _____

Designee of Child and Adult Psychological Services, PLLC, Date