Serenity Counseling LCSW PLLC

20 Medford Avenue Suite 109
Patchogue, New York 11772
Phone 704-458-3025
fpredarrow1@gmail.com

Client Name: _____SSN _____

Record Number: _____DOB: _____

I _____ hereby authorize _____

(Client or Personal Representative) (Name of Provider)

To release/exchange specified health information in my child's record to:

_____

(Recipient Name/Address /Phone/Fax)

This information shall include (staff initial any that apply):

	Psychological Evaluation		HIV
	Psychiatric Evaluation		Alcohol and Drug Screen
	Progress Notes from _____to _____		STD
	Admission Note		Hepatitis
	Diagnosis		Tuberculosis
	Person Centered Plan		Medication
	Education Information (IEPs, educational evaluations, etc.)		Medical Records
	School Behavior Reports		Financial
	Other:		
	Disclosures made regarding:		

I understand this information will be used for: ___Continuity of Care ___Referral and Evaluation___Case Management___

Other: _____

I understand that this authorization will expire on the following date, event or condition:

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.
I further understand that I may request a copy of this signed authorization.

_____ _____ _____ _____

Signature of Client Date Witness-If required Date

_____ _____ _____

Signature of Personal Representative Date Personal Representative Relationship/Authority

Note: This authorization was revoked on:

_____ _____

Signature Staff Date

_____ _____

Signature of Client Date

_____ _____ _____

Signature of Personal Representative Date Personal Representative Relationship/Authority

The original of this form should remain in the client file. A copy should accompany the released records.