Dawn Wilcox, LCSW

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____DATE OF BIRTH: _____

ADDRESS: _____ TELEPHONE: _____

_____

I hereby authorize my Treatment Provider to disclose my health information to:

_____

Phone: _____ Fax: _____

The information to be disclosed to and used by the above is for the following purpose:

Continuing Care_____ Attorney/Legal_____ Insurance_____

Other_____

Information to be faxed to the receiver: Yes: _____ Fax #: _____ No: _____

Information to be disclosed: (check only if YES)

____ **Complete Record**	____ **Psychiatric Evaluation**	____ **Current Treatment Update**
____ **Medication Management**	____ **Admission Assessment**	____ **Progress Notes**
____ **Child Study Team Information**	____ **Diagnosis**	____ **Treatment Summary**
____ **Medical Information**	____ **Educational Information**	____ **Psychosocial Evaluation**
____ **Discharge Summary**	____ **Legal Records/Information**	____ **Other**

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, BEHAVIORAL OR MENTAL HEALTH SERVICES AND INFECTIOUS DISEASE information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing. Furthermore, I understand the revocation will not apply to the extent that my Treatment Provider has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility of benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my Treatment Provider at (732) 735-5572.

Date: _____

Patient Signature: _____

Patient is age 14 years or older: ____**Yes** ____**No**

For Office Use Only: Dawn Wilcox, LCSW

Date Information Release: _____

Signature: _____