NeuroPsychCPS

Trusted • Compassionate • Excellence

173 Huguenot Street, Suite 200
New Rochelle, NY 10801
Phone: (914) 246-4100 Fax: (914) 888-301-8044

AUTHORIZATION for RELEASE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT INFORMATION:

Patient's Last Name: _________________________ First Name: ______________________________ MI: _____

Date of Birth: ________________________________ Telephone Number: ________________________________

INFORMATION RELEASED TO AND/OR RECEIVED FROM:

Name of Person, Agency or Program: ____

Address: ____

City: ____ State: ______________ Zip: __________________

Telephone: ____ Fax: ____________________________________

PURPOSE FOR DISCLOSURE:

	Referral for services from provider		Insurance claim
	Coordination of services between providers		Personal use
	Legal / attorney inquiry		Other: ________________________________

I understand that the information in my mental health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), if any. It may include information about treatment for alcohol and drug abuse.

I understand that I can revoke this authorization at any time by giving written notice of revocation to Neuropsychological & Clinical Psychotherapeutic Services, PLLC (NeuroPsychCPS). I understand that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I understand that this authorization is valid for six months from the date signed, unless I revoke the authorization or unless an earlier date is specified here: ________________________.

I understand that NeuroPsychCPS, cannot control how the authorized person or organization uses or shares the information. I understand that once the information is received by the authorized person or organization, it may be subject to disclosure and may no longer be protected by federal privacy laws.

SIGNATURE:

I have reviewed the above information and hereby authorize the above use and disclosure:

____ Date: ______________________________

Printed Name: ____

Relationship to patient: [ ] Self [ ] Parent / Guardian (if child) [ ] Other ______________________________

FOR OFFICE USE ONLY

I have reviewed this request and have authorized the release of the requested mental health records:

Clinician: ____ Date: ____________________________