Jennifer Trudeau-Brown, LMHC, ATR

Licensed Mental Health Counselor & Registered Art Therapist

**58 Henry Street, Saratoga Springs, NY 12866**

**P: 518.330.6585 F: 518.581.3182** www.oneroofsaratoga.com

## AUTHORIZATION FOR RELEASE OF INFORMATION

**Patient Name:** ______________________________ **Patient DOB:** ____________________

**Guardian Name:** ______________________________ **Relationship:** ____________________

I,__________________________________ hereby authorize Jennifer Trudeau-Brown, LMHC, ATR,

to disclose and/or obtain information from:

Contact Name: ______________________________

Relationship/Role/Organization: ______________________________

Address: ____________________________________

Phone Number: ______________________________

Fax Number: _______________________

**Description of Information to be Disclosed:**

______ Assessment

______ Diagnosis

______ Psychosocial Evaluation

______ Psychological Evaluation

______ Progress in Treatment

______ Treatment Plan or Summary

______ Current Treatment Updates

______ Other:______________________________________________________________________________

_____ Nursing/Medical Information

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Demographic Information

_____ Presence/Participation in Treatment

I understand that the purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: ___________________________

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I understand that confidential information cannot be disclosed without my written consent unless in cases where safety concerns are present pursuant to state and federal laws requiring mental health professional mandated reporting (for example: suspected child abuse, health or mental health emergency). Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Jennifer Trudeau-Brown, LMHC, ATR, at 58 Henry Street, Saratoga Springs, NY 12866. However, I understand that my revocation will not be effective to the extent that Jennifer Trudeau-Brown, LMHC, ATR, has taken action in reliance on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Unless sooner revoked, this consent expires on the following date: _________________ or as otherwise indicated:

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is more strict than HIPAA and provides additional privacy protections.

I further understand that Jennifer Trudeau-Brown, LMHC, ATR, will not condition my treatment on whether I give authorization for the requested disclosure. I understand I will be given a copy of this document for my records, upon request. However, it has been explained to me that failure to sign this authorization may have the following consequences

(please describe):

___________________________________________ __________________

**Signature of Patient or Parent/Legal Guardian** **Date**

___________________________________________

**Print Name**

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If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____Check here if patient/client or parent/guardian refuses to sign authorization

_______________________________________ __________________

**Signature of Mental Health Provider** **Date**