Emily Pimpinella, Psy.D.
Clinical Psychologist

Authorization For the Release of Confidential Information

1. I, _____, Date of Birth, _____/_____/_____, hereby authorize Emily Pimpinella, Psy.D., at 213 North Aurora Street, Ithaca, NY 14850, to:

_____ Seek Information From _____ Release Information To _____ Both Seek Information From and Release Information To

_____

(Person, Organization, Agency, Company)

Address: _____

Phone: _____ Fax: _____

2. I am hereby authorizing the disclosure of the following protected health information (client will initial):

_____ Attendance _____ Progress _____ Treatment Records

_____ Treatment Plan _____ Recommendations _____ Treatment Summary

_____ Other: _____

3. This authorization may include disclosure of information related to the following types of protected health information only if I place my initials where appropriate below, my initials serving as my signature release for each type of protected health information.

_____ Mental Health and Alcohol/Substance Abuse Treatment Information[a]

_____ Confidential HIV Related Information[b]

a. Although I am authorizing this release of Alcohol/Substance Abuse treatment information to the recipient, the recipient is prohibited from re-disclosing this information without my authorization unless specifically permitted to do so under federal or state law.

b. HIV is the Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts, including HIV test results. If I am authorizing the release of HIV-related information, I understand that the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law and I have the

213 North Aurora Street
Ithaca, NY 14850
Phone: 607-273-1083
Fax: 607-273-1183

4. This protected health information is being used or disclosed for the following purposes:

Confirmation of attendance: ( )
Referral: ( )
At the individual's request ( )
Coordination of Treatment: ( )
Insurance Purposes: ( )
_____: ( )

5. Unless revoked earlier, this consent will expire on:

90 Days following signature: ( )
Upon Completion of Treatment: ( )
1 Year from date signed: ( )
_____: ( )

6. Please initial all that apply.

_____ I agree that a photocopy of this form is acceptable.
_____ I authorize this release to be faxed to the aforementioned person, organization, or agency.
_____ I have received a copy of this authorization form.
_____ I understand that I have a right to receive a copy of this authorization, however, I have declined to obtain one.

7. I have had explained to me and fully understand and accept this request/authorization to disclose records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. Further, I understand that, if the person or organization who receives this information is not a health care provider or health insurer, the information may no longer be protected by federal privacy regulations. I understand that I have the right to revoke this authorization, in writing, at any time.

_____ _____
Signature Client/Parent of Minor Client, Or Personal Representative of Client (If a Personal Representative, also state relationship to Client)
Date