Emily Pimpinella, Psy.D.

213 N. Aurora St

Ithaca NY, 14850

Authorization for Release of Confidential Information

Client's Name: _____

Client's Date of Birth: _____

Your Relationship to the Client:

_____ Self

_____ Parent or Guardian

_____ Legally Appointed Representative

_____ Other: _____

I hereby authorize Emily Pimpinella, Psy.D. to:

_____ Seek Information From

_____ Release Information To

_____ Both Seek Information From and Release Information To

Person, Organization, Agency, Company:

_____

Address:

_____

_____

_____

_____

Phone Number and Fax Number (if known): _____

I am hereby authorizing the following disclosure of protected health information (select all that apply):

_____ Entire Treatment Record

_____ Treatment Records for a Specific Date or Date Range:_____

_____ Written Summary of Evaluation and Treatment

_____ Discuss Evaluation and Treatment Information Verbally

_____ Other:_____

This authorization may include disclosure of information relating to the following types of protected health information (select all that apply):

_____ Mental Health and Alcohol/Substance Abuse Treatment Information

_____ Confidential HIV Related Information

This protected health information is being used or disclosed for the following purposes (select all that apply):

_____ Coordination of Treatment

_____ At the Request of the Individual

_____ Referral

_____ Insurance/Payment Purposes

_____ Determining Eligibility for Benefits or Program

_____ Other:_____

Unless revoked earlier, this consent will expire on (select one):

_____ 90 Days From Date Signed

_____ 1 Year From Date Signed

_____ Upon Completion of Treatment

_____ Other:_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.

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. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

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 permit this authorization form to be copied or faxed, and agree that these versions of the form shall be considered as effective and valid as the original. I may also receive a copy of this authorization form, if desired. I understand that I have the right to revoke this authorization, in writing, at any time.

_____ _____

Signature Date

_____

Print Name