Port Jefferson Psychological & Vocational, P.C.
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PERMISSION FOR OBTAINING/RELEASING CONFIDENTIAL INFORMATION

This form when completed and signed by you, authorizes Port Jefferson Psychological & Vocational PC to release protected information from your clinical record to the person you designate.

PATIENTS NAME: _____

I authorize Port Jefferson Psychological & Vocational, P.C. to
RELEASE information to / OBTAIN information from:

_____
Name Address Phone Number

Provide description of the information that you want disclosed _____

_____

I am requesting my therapist to release this information for:
__ at the request of the individual
__ to coordinate treatment
__ other: _____

This authorization shall remain in effect until
__ perpetuity
__ one year
__ other: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization. If this authorization is being used to obtained third-party payment, you will be responsible for all fees if your revocation results in non-payment from the third-party payor.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and may no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient/Parent Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.