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Authorization to Release Information

To
Name of Agency:

____

Address:

____

Phone: ______________________________

Fax: ______________________________

Regarding
Name of Individual:

____

Date of Birth:

____

Address:

____

Release of Medical/Mental Health Records
My signature below authorizes Westfield Mental Health Specialists, and the agency or professional to whom this form is addressed, to use, release, and freely exchange mental health and Protected Health Information ("PHI") and records regarding the individual listed above that were generated during treatment:

☐ currently OR ☐ on or about the following dates ______________________

The purpose of the use or disclosure is for:
☐ Request of Individual or
☐ Parent/Legal Guardian
☐ Treatment Planning
☐ Court Proceedings
☐ Other ______________________

I hereby authorize and request the release, disclosure, and use of information specifically limited to the items checked below. This authorization extends to all of the records/information designated below which may include information regarding:
☐ Alcohol/Drug Abuse
☐ Sexually Transmitted Infection and/or HIV/AIDS

Information to be used/released:
☐ Discharge Summary
☐ Medical History and Examinations
☐ Medication Records
☐ Psychiatric Evaluation
☐ Psychological Testing Results
☐ Psychotherapy Notes
☐ Education - Clinical Progress (e.g., counseling)
☐ Education - IEP/School Assessments/ Assignments
☐ Education – Observation of Student
☐ Therapist/Social Services Progress Notes
☐ Treatment Plans
☐ Verbal Communication - No Restrictions
☐ Verbal Communication - Restrictions:
____
☐ Other: ______________________
☐ All information, no restriction

Notice to Patient and Recipient of Records

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and New Jersey Public Law 303. This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and New Jersey Public Law 303. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have been informed and understand that this authorization is subject to revocation by me at any time except to the extent that Westfield Mental Health Specialists has already taken action in reliance on it. If I do not revoke this authorization it will automatically expire 1 year from the date of signature unless otherwise noted. Once the requested protected health information is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient rediscloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Westfield Mental Health Specialists from all liability should this information be received by someone other than the above-intended recipient. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV data.

This consent is effective beginning on:____, and expires on

____, if not revoked earlier.

Patient Signature (ages 14 and older) — Date

Parent/Guardian Signature — Date

Parent/Guardian Signature — Date

Witness Signature — Date