Hillside Psychology. P.L.L.C.

40 W. Main St. Mount Kisco, NY 10549

Tel: (914) 401-0215

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Authorization for Release of Information

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your health information for the purposes described below unless there is a serious or imminent threat to the health and safety of you or others. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

Please read the information below before completing and signing this form

I, or my authorized representative, request that health information regarding my care and treatment at Hillside Psychology, P.L.L.C. be released by Hillside Psychology, P.L.L.C. to the party named below.

Please be advised that if your health records contain information relating to HIV (Human Immunodeficiency Virus that causes AIDS), New York State requires a separate written authorization for release of this information. Please inform Dr. Barbara Meehan if you need to sign the NYS authorization form.

1. Name of person whose information will be released (Please Print): _____

Date of Birth: ____ / ____ / ____ Address: _____

2. Names and addresses of persons receiving this information:

_____

_____

_____

3. Reason for disclosure of information:

☐Follow-up Patient Care ☐ Insurance -related matter ☐Individual's Request ☐Other (please specify): _____

4. By signing this form, I authorize release and disclosure of information regarding my treatment at Hillside Psychology, P.L.L.C. (include dates where appropriate).

5. By signing this form, I give consent for _____ to speak to _____ regarding my case.

6. Date or event that will trigger the expiration of this authorization: _____

☐One time only ☐3 months ☐ 6 months ☐ 9 months ☐ One Year ☐ Other: _____
Specify event (must relate to patient or purpose for disclosure): _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to:

Hillside Psychology, P.L.L.C
c/o Barbara Meehan, Ph.D.
P.O. Box 72
Somers, NY 10589

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the information disclosed may be re-disclosed if the recipient(s) described in this form is not required by law to protect the privacy of the information, and the information is no longer protected by health information privacy rules. My questions about this form have been answered and the above required information has been completed.

Signature of Patient or Personal Representative Date

If signed by Personal Representative, description of Representative's authority