AUTHORIZATION FOR RELEASE OF INFORMATION:

I,**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** whose date of birth is

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** authorize Irina Volynsky, Ph.D to disclose to and/or obtain from **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**the following information:

**Description of information to be Disclosed:**

(Patient/Client should initial each item to be disclosed)

\_\_\_\_Assessment \_\_\_\_Toxicological Reports/Drug Screens

\_\_\_\_Diagnosis \_\_\_\_Education Information

*\_\_\_\_*Psychosocial Evaluation \_\_\_\_Discharge/Transfer Summary

\_\_\_\_Psychological Evaluation \_\_\_\_Continuing Care Plan

\_\_\_\_Psychiatric Evaluation \_\_\_\_Progress in Treatment

\_\_\_\_Treatment Plan or Summary \_\_\_\_Demographic Information

\_\_\_\_Current Treatment Update \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Presence/Participation in Treatment \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Revocation:**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Irina Volynsky, Ph.D at 440 West Street, Suite 323, Fort Lee, NJ 07024. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**SEE REVERSE OF PAGE FOR CONTINUATION.**

**Expiration:**

Unless sooner revoked, this consent expires on the following date: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or unless otherwise indicated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**(If calendar date is not stated, information may only be released on the date the authorization is received.)**

**Conditions:**

I further understand that Irina Volynsky, Ph.D will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Form of Disclosure:**

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

**Redisclosure:**

State and Federal law prohibits the person or organization to whom disclosure is made form making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

­­­­­­­­­­­­­­­­­Signature of Patient/Client (14 years of age and older) Date

Signature of Parent, Guardian, or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act this individual (power of attorney, healthcare, healthcare surrogate, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_Check here if patient/client refuses to sign authorization

Signature of Staff Witness (Attesting to Identity and Authority) Date