NYFS Northeast Youth & Family Services

Authorization for Release of Information

CLIENT: _____ DOB: _____

I hereby give my permission for Northeast Youth & Family Services to:

Check at least one: ***Release***: _____ ***Receive From***: _____

Individual's Name: _____ Phone: _____ Fax: _____

Organization & Address: _____

City: _____ State: _____ Zip Code: _____

1. ***Purpose for which this information may be disclosed:***
   ____ Treatment/Continued Care _____ Client Request _____ Legal Purpose and/or other (please explain):

2. ***The information that may be disclosed****: Check at least one*
   a. My entire health record: _____ ***Initial giving consent***: _____

   b. Part of my health record: _____ ***Initial giving consent:*** _____

   _____ psychological assessment _____school records _____social service/court records
   _____diagnostic assessment _____treatment plan _____discharge summary
   _____medical records _____medication management notes
   _____ongoing communication _____psychiatric assessment

   c. If initialed here, psychotherapy progress notes may be released: _____

   d. If initialed here, my chemical health treatment program record may be disclosed: _____

3. ***Dates of visits*****:** Only my most recent visit: _____ Visits from: _____ to _____

4. ***This authorization expires (ends) on the following date, event or condition:*** _____
   - This authorization will expire no more than twelve (12) months from the date I sign this form, unless otherwise specifically permitted by law.

I understand that*:*

- I may revoke this authorization at any time by notifying in writing Northeast Youth & Family Services.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or obtain a copy of the health information to be disclosed.
- If the disclosed information goes to a healthcare provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be re-disclosed.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is *not* contingent upon my signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company.

Signature of Client or Client Representative: _____ Date: _____

Printed Name of Representative: _____ Relationship to Client: _____