Riverview Psychological Services, P.C.
❑ **660 Stoneleigh Ave., Carmel, NY 10512**
❑ **209 Old Route 9, Fishkill, NY 12524**
Phone / Fax: (845) 875-7133

Authorization for Release of Protected Health Information (PHI)
— Mental Health Record —

1. PATIENT INFORMATION

Patient last name _____ First name _____ MI ____ Date of birth _____

Patient former name (if any) _____ Patient e-mail _____

Patient address _____
Street City State Zip

2. RECIPIENT AUTHORIZATION

I _____ do hereby authorize _____ to exchange my
Patient name or representative therapist of Riverview Psychological Services, P.C.

mental health information with the following person or facility below:

Name of person or facility _____

Street address _____ City, state, zip _____ Phone _____

3. INFORMATION TO BE RELEASED / TYPE OF DISCLOSURE

- ❑ Mental health information
- ❑ Medical information (This may include drug/alcohol and mental health information documented by a primary care practitioner)
- ❑ Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§2.34 and 2.35).
- ❑ Only the following information: _____

TYPE OF DISCLOSURE: ❑Verbal Information ❑ Copies of records ❑ Letter ❑ Proof of Attendance

4. PURPOSE OF INFORMATION RELEASE

❑ Further mental health care ❑ Payment of insurance claim ❑ Legal investigation ❑ Applying for insurance
❑ Vocational rehab, evaluation ❑ Disability determination ❑ At the request of the individual
❑ Other (specify): _____

5. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to Riverview Psychological Services, P.C., except to the extent that Riverview Psychological Services, P.C. has already completed action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release Riverview Psychological Services, P.C. from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of one year, and it automatically expires one year after the date this form is executed.

6. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____ Date _____
Signature

Personal representative (if applicable): _____
Printed name of personal representative

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing:

Patient is: ❑ minor ❑ incompetent ❑ disabled ❑ deceased

Legal authority: ❑ parent ❑ legal guardian ❑ next of kin of deceased