

**Riverview Psychological Services, PC
66 Middlebush Rd. – Suite 300
Wappingers Falls, NY 12590
Phone/Fax: 845-875-7133**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____
(Print Full Name of Patient) (Date of Birth)

hereby authorize the release of my health information

between:

Practitioner or therapist name: _____
Riverview Psychological Services, PC
66 Middlebush Rd. – Suite 300
Wappingers Falls, NY 12590

and:

Name: _____
Address: _____
City, State, Zip: _____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: Further mental health or medical care _____ Letter _____
(check all that apply) Legal investigation _____ Insurance request _____
Other: _____
Information requested: Copies of records (progress notes, test reports), verbal information,
letter, proof of attendance, or other: _____

I give my permission for the information listed above to be exchanged between the above-named individuals or organizations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire one year after the date signed. The above-named individuals or organizations should not redisclose my medical record to another party without further written consent.

I will not hold above-named individuals or organizations nor Riverview Psychological Services, PC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking above-named practitioner for clarification of the information therein.

Date: _____ **Patient signature:** _____

Date: _____ **Personal representative (if applicable*):** _____

*** If patient is a minor, incompetent, disabled, or deceased**