Riverview Psychological Services, PC
Fishkill, NY 12524
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
209 Old Route 9
Fishkill, NY 12524

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: (check all that apply)	**Further mental health or medical care____ Letter____** **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**