North Shore Behavioral Health Services, LCSW P.C.
88 Terry Rd.
Smithtown, NY 11787
(631) 559-7033

HIPAA AUTHORIZATION FORM

Name of Client: _____DOB:_____

I authorize (name, address, phone number) _____

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to disclose to and/or obtain from North Shore Behavioral Health the following information:

___Relevant Clinical Information __Presence /Participation in Treatment ___ Diagnosis

___ Current Treatment Update __ Continuing Care Plan ___ 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 the right to revoke this authorization, in writing, at any time by sending written notification to North Shore Behavioral Health to the office address above. 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.

Expiration:

This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

Conditions:

I further understand that North Shore Behavioral Health will not condition my treatment on whether I give authorization for the requested disclosure.

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, paper format or electronically.

Re-Disclosure:

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part2. Other types of information may be re-disclosed by the recipient of the information in the following circumstance:
_____

I will be given a copy of this authorization for my records.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date