Amy M. Rosenthal
Licensed Clinical Social Worker
929-382-4251
https://www.arosenthallcsw.com/

Authorization For Release of Information

Date: _____

Client Name: _____ Date of Birth: _____

I, _____, hereby authorize Amy M. Rosenthal, LCSW to release
(client or legal guardian's name)

and/or receive the following information concerning myself or my child to/from:

Name: _____

Address: _____

Phone Number: _____

The type of information to be disclosed:

Evaluations _____	Medical/Hospital Records _____
Diagnosis _____	Mental Health Record Summary _____
Course of Treatment _____	Billing Information _____
Scheduling _____	Other (please specify) _____

The purpose of such disclosure:

Ongoing Treatment _____ Medical Care _____

Consultation _____ Evaluation _____

Transfer _____ Coordination of Care _____

Health Benefit Utilization _____ Financial Remuneration _____

Other (please specify) _____

Exceptions:_____

The designated information about me may ( ) may not ( ) be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Amy M. Rosenthal, LCSW and the above designated person may ( ) may not ( ) discuss by telephone the content of the information released.

This consent is in effect until_____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Date: _____

Signature of Client or Legal Guardian: _____

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.