22 Oakwood Road
Huntington, NY 11743
P: (631) 223-8499

Psychological Services, PLLC

280 Madison Ave #202
New York, NY 10016
P: (347) 915-3044

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ____

I authorize the clinical and administrative staff at Family Guiding Psychological Services, PLLC to release the following information regarding the protected health information of above named:

Verbal: ☐ All Information Necessary ☐ No Information ☐ Only: ________________________

Written: ☐ All Information Necessary ☐ No Information ☐ Only: ________________________

This Information should only be released to:

Name of Person/Organization: ____

Address of Person/Organization: ____

Phone Number: ____________________________ Fax Number: ____________________________

The authorization shall remain in effect until:

☐ Revoked by me in writing

☐ Date (fill in a expiration date or event that relates to the individual or purpose of the disclosure

____

You have the right to revoke this authorization, in writing, at any time by delivering such written notification to our agency. Please note that your revocation will not be effective to the extent that action has already been taken in reliance of this authorization or if this authorization was obtained as a condition of obtaining insurance coverage.

I understand that this form, when completed and signed by me, authorizes professionals with Family Guiding Psychological Services, PLLC to release verbal information or written information from my records to the person/organization designated above. I understand that this may contain references to mental health, treatment progress and/or prognosis:

____

(Printed Name of Person, Parent/Guardian
or Authorized Representative)

____ ______________________

(Signature of Person, Parent/Guardian
or Authorized Representative)

(Date)