

Julie S. Nathan, Ph.D.

330 W. 58th Street
Suite 313
NYC, NY 10019
917.846.5194

100 Union Ave
Suite 110
Cresskill, NJ 07626
jnathanphd@gmail.com

Authorization For Disclosure of Mental Health Treatment Information

I, _____ (Name of Patient) authorize the health care practitioner, Julie Nathan, PhD (the Practitioner) to disclose to and/or obtain protected health information regarding myself / my child _____ from _____ (Name of Person or Title of Organization).

I am hereby authorizing the disclosure of the following protected health information (please check all that apply):

_____ assessment	_____ (neuro) psychological testing
_____ diagnosis	_____ billing only
_____ treatment plan or summary	_____ presence/participation in treatment
_____ current treatment update	
_____ discharge / transfer summary	

This information may be used or disclosed in connection with mental health treatment, payment or healthcare operations.

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.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the Practitioner at the 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 that authorization.

The Practitioner will not condition my treatment on whether I provide an authorization for disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Unless I have specifically requested in writing that the disclosure be made in a certain format, the Practitioner has the right to disclose information as permitted

by this authorization in any manner she deems to be appropriate and consistent with the applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

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

Signature of Patient or Parent of Minor Patient

Date

Personal Representative of Patient

If you are signing as a Personal Representative of an Individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc). _____