



# Andrew Weissman, Psy.D., P.C.

## Clinical Psychologist

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Request records to be sent     Please call for phone consult when received     Authorization for phone consult

Information about you and your treatment cannot be exchanged without your consent. Your signature on this release authorizes information to be exchanged for the indicated purpose.

I authorize the release of records, including those that may contain confidential HIV/AIDS related information, confidential communicable disease related information and confidential mental health and/or alcohol/drug use related information.

When completed and signed, this document authorizes the exchange of confidential information regarding the following client:

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Social Security Number :** \_\_\_\_\_

**Between** \_\_\_\_\_ **and;**

**Name:** \_\_\_\_\_ **Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

\_\_\_\_\_ **Fax:** \_\_\_\_\_

Information to be Exchanged	Purpose:
<input type="checkbox"/> Attendance only <input type="checkbox"/> Summary of attendance and progress <input type="checkbox"/> Complete records <input type="checkbox"/> Portions of case records, as specified: _____ _____ <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> To assist in making appropriate referral. <input type="checkbox"/> To coordinate and assure continuity of care. <input type="checkbox"/> To arrange leave of absence from work or return to work. <input type="checkbox"/> To comply with court order, subpoena, employer request, or other appropriate requests for information. <input type="checkbox"/> Other: _____ _____

**Prohibition on Redisclosure:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

I understand that I may revoke this authorization at anytime, except to the extent that action based on this authorization has already been taken. This consent will expire automatically *twelve months* from the date on which it is signed. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purposes of this disclosure.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date