WESTCHESTER CENTER FOR THE STUDY OF PSYCHOANALYSIS AND PSYCHOTHERAPY

# CONSENT FOR RELEASE OF INFORMATION

See Reverse Side for Instructions

Client's Name | Case Number

Facility Name & Address :
WCSPP 1889 Palmer Avenue, Suite 6
Larchmont, NY 10538

Treating Therapist /Candidate Name:

## PART I - CONSENT TO RELEASE INFORMATION

Extent or Nature of Information to Be Disclosed

Purpose or Need for Information

Evaluation and treatment.

| TO/FROM -Name & Address of WCSPP Candidate Disclosing Information: | TO/FROM - Name & Address of Person or Organization to which Disclosure is to be Made |
|---|---|
| | |

I hereby authorize the release of the above information from my medical record.

- I understand that the information to be released from my medical record is confidential and protected from disclosure.
- I also understand that my consent to release information will expire one year from this date if not acted upon prior to that time.
- I also understand that I have the right to cancel my permission to release information at any time before it is released by filling out and signing the back of this form.
- I also understand that treatment is not conditional based on my willingness to sign this authorization, except in certain circumstances permitted under the HIPAA privacy rule.

Please Note:

As a HIPAA covered entity, we are required to inform you that when we disclose your Protected Health Information (PHI) to another entity either by authorization or as required by law, we have no means of controlling their internal use and/or further disclosure of that information. When we disclose to HIPAA covered entities, however, they are required by law to afford the same protections to your PHI as this agency.

| Signature of Client | | | Date Signed |
|---|---|---|---|
| Signature of Witness | Print Name Signed | Title | Date Signed |
| Signature of Person Acting for Client | Print Name Signed | Relationship to Client | Date Signed |
| Signature of Witness | Print Name Signed | Title | Date Signed |

## RECORD OF INFORMATION RELEASED

| Signature of Staff Member Releasing Information | Print Name Signed | Date Released |
|---|---|---|
| | | |

Use Part II on Reverse Side to Record Cancellation of Existing Consent to Release Information or Refusal to Allow Release of Information.

## PART II - CANCELLATION/REFUSAL TO RELEASE INFORMATION

| I hereby cancel my permission to release information from my Medical Record to the person or organization whose name and address is: | I hereby refuse to authorize the release of information from my Medical Record to the person or organization whose name and address is: |
|---|---|
| | |

| Signature of Client | | | Date Signed |
|---|---|---|---|
| Signature of Witness | Print Name Signed | Title | Date Signed |
| Signature of Person Acting for Client | Print Name Signed | Relationship to Client | Date Signed |
| Signature of Witness | Print Name Signed | Title | Date Signed |

### INSTRUCTIONS

1. When sending information to an Agency/Individual, complete a separate form for each request. Affix date and signature when information is released. File in Client case record.

2. When requesting information from an Agency/Individual, complete a separate form in duplicate for each request. Send original to agency/individual. File copy in Client case record.

3. If Client is over 12 years of age and under 18 years of age, Client and responsible parent, relative or guardian must sign. Exception: If Client is a voluntary admission on own application, at least 16 years of age but under 18 years of age, only the Client must sign.

4. If Client is under 12 years of age, the responsible parent, relative, or guardian must sign.