Judi Oshinsky Psychotherapy LLC
Judith Cohen Oshinsky, M.S.S.W., L.C.S.W.
Psychoanalytic Psychotherapy

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Authorization for release of Information

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,

Address:_____
_____

Phone:

authorize Judith Cohen Oshinsky, LCSW to disclose to and/or obtain from:

_____ the following information:
[Insert Name and contact information of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Assessment
_____Psychiatric evaluation
_____ Treatment Plan /Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____Medical information
_____Neurological Evaluation
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Mental Status
_____Closing Summary
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. _____.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Judith Cohen Oshinsky, LCSW at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Conditions

I further understand that Judith Cohen Oshinsky, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However it has been explained to me that failure to sign this consent form will prohibit my psychotherapist from collaborating with my other health care professionals and may limit the effectiveness of my treatment.

I understand that: I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights). I have the legal right to have specific information within those records withheld. I have the right to receive a copy of this authorization for my records.

Form of Disclosure

I understand that unless I have specifically requested in writing that the disclosure be made in a certain format, Judith Cohen Oshinsky, reserves the right to disclose information as permitted by this authorization in any manner that she deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

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.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

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.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date