David Flomenhaft
PSYCHOTHERAPY
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Authorization for the Release (Disclosure) of Protected Health Information (PHI)

Patient Name: _____

Full Address: _____

Phone #: _____ Date of Birth: _____

Type of Authorization Release:

☐ I authorize David Flomenhaft, LCSW, PhD, to **RELEASE** PHI to:

_____

_____

Name, address, phone number, fax if applicable

☐ I authorize David Flomenhaft, LCSW, PhD, to **OBTAIN** PHI from:

_____

_____

Name, address, phone number, fax if applicable

Extent and nature of information to be disclosed, including dates of treatment or hospital:

Coordination of Care _____

Educational Functioning _____

☐ Complete Record ☐ Progress Notes ☐ Mental Health Treatment

Purpose or need for the disclosure (please check one of the following):

☐ Attorney ☐ Insurance ☐ Medical Care (seeking a consultation) ☐ Personal ☐ Other

1. This authorization is applicable to patient with drug- or alcohol-related diagnoses, in which Title 42, Part 2 of the Code of Federal Regulations and/or the New York State Mental Hygiene Law, governs this request.
2. Treatment and payment will not be conditional on whether I provide authorization for any requested disclosure by David Flomenhaft, LCSW, PhD.
3. This authorization may be revoked by written notification from the undersigned to David Flomenhaft, LCSW, PhD.
4. This authorization will expire one year from the date entered below.

_____ _____

Signature of patient or personal representative, e.g., legal guardian | Relationship to patient

_____ _____

Print name if other than patient | Today's date

_____

Address and telephone number of patient or representative

_____

Signature of witness