Child Advocacy & Parent Empowerment Services
Deanna Walsh-Bender, M.S.Ed., L.M.S.W.

AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient: _____ Date of Birth: _____

1. I authorize the mental healthcare practitioner Deanna Walsh-Bender, MSEd, LMSW @ 542 North Country Road, Suite 2, St. James, New York 11780 (the "Practitioner") and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information (PHI), as specified below, to:

2. This protected health information is being used or disclosed for the following purposes:

❍ At the request of the individual to facilitate comprehensive treatment ❍ Other:_____

3. I specifically authorize the disclosure _____ By _____ To the Practitioner the following types of PHI. My initials, placed where appropriate below, serve as my signature release for each type of specific PHI.

_____	Psychotherapy Notes (as defined by HIPAA)	_____	Psychological Evaluation
_____	Confidential HIV Related Information [1]	_____	Educational Evaluation
_____	Alcohol/Substance Abuse Treatment Information [2]	_____	Social History
_____	Treatment Plan	_____	Student Observation
_____	Admission & Discharge Diagnosis, Dates of Treatment & Discharge Summary	_____	Speech Evaluation
_____	Medication Regimen	_____	PT/OT Evaluations
_____	Current Class Schedule	_____	FBA & BIP
_____	Last 3 Years of Incident Reports, Superintendent's Hearing &/or Suspension Records	_____	IEP
_____	Last 3 Years of Report Cards and Progress Reports	_____	Last 3 Years of Attendance Records

4. 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.

5. 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 understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law, provided however, that Confidential HIV Related Information and Alcohol/Substance Abuse Treatment Information may not re-disclosed without my authorization unless permission to re-disclose such information is granted by federal or state law.

7. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

X_____ _____
Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient — Date

X_____
Print Patient Name, Parent of Minor Patient or Personal Representative (If a Personal Representative, state relationship to patient.)

1. HIV is the Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts, including HIV test results. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. Although I am authorizing this release of HIV-related to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.
2. Although I am authorizing this release of Alcohol/Substance Abuse treatment information to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.