Behavioral Health Services of the Hudson Valley
633 Gidney Ave. Suite 6, Newburgh, NY 12550 Phone: 845.569.2900 Fax: 866.619.5710 Web: BHSHV.com

AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH INFORMATION

PART I:

I, _____, hereby authorize _____ to
(Name and DOB of Patient) (Psychiatrist/Clinician-address above)
release/receive the general, mental health and substance use related health care information described below to:

Name, address and phone of person/organization releasing/receiving information:
Primary Care Physician _____
_____
_____

This request and authorization applies to the following protected healthcare information:
- ☐ Psychosocial Assessment
- ☐ Progress Notes
- ☐ Other:_____
- ☐ History
- ☐ Relevant Case Data

The purpose for use or release/receipt of this information is:
- ☐ Coordination of treatment services
- ☐ Referral
- ☐ Discharge planning
- ☐ Specific purpose:_____

This request and authorization will expire:
- ☐ 3 years after last date of service
- ☐ When acted upon/once specific disclosure has been made
- ☐ On this specific date:_____

I understand that, except for action already taken, I may revoke this authorization in writing at any time by delivering or sending written notification to my therapist or physician at 633 Gidney Ave., Suite 6, Newburgh, NY 12550.

I also understand that I have the right to receive a copy of this authorization and that a copy will be maintained in my patient record. I understand that I have the right to refuse to sign this authorization.

I request that payment of authorized benefits be made on my behalf to Behavioral Health Services if the Hudson Valley or my specific provider for services furnished to me by the provider. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law.

Please sign below to authorize the use or release of your personal health information for the reasons and with the conditions established above:

_____ _____
Signature of Patient Date

_____ _____
Witness Date

PART II: Cancellation/Refusal to Release Information

☐ I hereby cancel my permission to release/receipt information indicated in Part I, to the person/organization whose name and address is: _____

☐ I hereby refuse to authorize the release/receipt of information indicated in Part I, to the person/organization whose name and address is:_____

_____ _____
Signature of Patient Date

_____ _____
Witness Date

Part III: Consent Review and Update:
I have reviewed the above information and agree that it remains accurate and I continue to consent to its release.

_____ Patient Initials _____Date _____ Patient Initials _____ Date
_____Patient Initials _____ Date _____ Patient Initials _____ Date