GRUNBLATT PSYCHOLOGY AND COUNSELING OFFICES, P.C.

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Authorization Form (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient: _____

1. I authorize the Healthcare practitioner Grunblatt Psychology and Counseling Offices, P.C., 124 Green Street, Kingston, New York 12401 (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, as specified below to:_____
_____(name and address of person/entity to receive information)

2. I am hereby authorizing the disclosure of the following protected health information:
_____
_____
__(Specifically describe the protected health information to be disclosed such as date of service, type of service, and level of detail to be released.)

3. This protected health information is being used or disclosed for the following purposes: _____At the request of the individual or_____ (enter specific reason)

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.

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.

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

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

I received a copy of this Authorization form _____ (please initial)