Hudson Valley Center for Development

CONSENT TO OBTAIN / RELEASE CONFIDENTIAL INFORMATION

By signing this document, I (name of Patient / Parent / Legal Guardian):____

(hereinafter "Patient"), hereby authorize the Hudson Valley Center for Development (hereinafter "Provider"), to release,

receive, and discuss information and records relevant to the Provider's mental health treatment of (Patient Name)____ with:

Name:____

Address:____

____

The disclosure of information and records authorized by Patient is required for the following purpose:

____

____

☐ Patient requests that disclosure be limited to the following specific types of information:

____

____

☐ The duration of treatment.
☐ Other date: ______________________

As the Patient, I understand that:

- This form authorizes release of protected health information. Your information may be protected from disclosure by federal privacy law and state law. By signing this form, medical information and/or mental health related information can be given or exchanged by the individual/organizations listed on the form.

- I have a right to receive a copy of this authorization. I agree that a fax or copy of this document shall be a valid authorization.

- Any cancellation or modification of this authorization must be in writing. I have the right to refuse to sign this form and that Provider shall not condition treatment upon my signing this authorization.

Patient or Legal Representative Signature: ____

Date: ____