Hudson Valley Center for Development

CONSENT TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION
With a Primary Care Provider and/or Psychiatrist

Please be advised that services at HVCD are provided by a variety of counseling professionals including but not limited to LCSWs, LMHC's, and PhD's. Every profession has differing requirements to maintain compliance with state laws. Section 8407 of NYS Education Law requires that LMHC's, LMFT's, LPsa's, and LCAT's, before providing their services to a patient with specific diagnosis and treatment needs on a continuous and sustained basis, must consult with the patient's physician (or psychiatrist) regarding the physician's medical evaluation of the patient in order to determine and advise whether medical care is indicated for the illness.

By signing this document, I (name of patient/parent/legal guardian):

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(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:

Primary Care/Prescriber Name: ______________________________________

Address: ____________________________________ Phone: ____________________

____________________________________ Fax: ______________________

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

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

____

This authorization shall remain valid until:

☐ The duration of treatment ☐ other date: ________________

As the Patient/legal Representative, 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 understand that in doing so I may not be able to be treated by the provider if they are an LMHC in accordance with Section 8407 of NYS Education Law.

Patient/ legal representative signature: ______________________________ Date: __________________

_________ I refuse to sign consent for my therapist to speak with my prescriber and/or my primary care doctor

Initial