BROCKPORT
MARRIAGE & FAMILY THERAPY, P.C.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL, EDUCATIONAL, AND CLINICAL INFORMATION

Please complete a separate form for any provider currently involved with family members engaged in treatment at Brockport Marriage & Family Therapy, P.C. and with whom you authorize your therapist to make contact, should this be necessary.

RE: ____ DOB: ________________

Full name of person engaged in treatment at BMFT

I am ☐ the person legally responsible for the above named individual
☐ the client, and I authorize Brockport Marriage & Family Therapy, P.C. to:

☐ **OBTAIN INFORMATION FROM** ☐ **RELEASE INFORMATION TO**

☐ Primary Care Physician — Facility/Name: ____________________
☐ Psychiatrist — Address: ____________________
☐ Agency — City, State, Zip: ____________________
☐ School — Fax: (   ) ____________________ Phone: (   ) ____________________
☐ Other - Name: ____________________ Relationship to client: ____________________

I authorize the disclosure of the protected health information by ☐ faxing, ☐ e-mail, ☐ oral, ☐ written
Specific information to be released or obtained:

☐ All necessary medical information necessary for medical treatment (e.g., immunization record, history of allergies & other medical complications, past history of medication use, recent blood work levels, EEG and EKG reports)
☐ All necessary evaluations necessary clinical treatment & services (e.g., psychiatric, psychological, social evaluations, comprehensive treatment plan(s) &/or review(s), special therapies)
☐ All necessary school/educational information for necessary educational services (e.g., report cards, IEP, testing, CSE minutes, permanent record)
☐ Discharge Summary
☐ Crisis/Safety Plan
☐ Other: ____________________

- This information is required for the purpose of any necessary and ongoing medical, clinical and educational needs inclusive of evaluations and recommendations for further treatment.
- I understand the information disclosed, as permitted by this authorization, may be re-disclosed by Brockport Marriage & Family Therapy, P.C., and may no longer be protected by Brockport Marriage & Family Therapy, P.C. after re-disclosure. I do understand that local, state & federal laws do exist to protect the confidentiality of this information.
- I understand that I have the right to revoke and/or restrict this authorization at any time, provided that I submit a request in writing. Any revocation shall not apply to the extent that Brockport Marriage & Family Therapy, P.C. has already taken action in reliance on *this* authorization.
- I authorize the periodic, on-going disclosure of the above information. This authorization expires *when services at Brockport Marriage & Family Therapy, P.C. are discontinued*. If authorization is granted following termination of services, the authorization will expire within 90 days after the date of the authorization.

I have been informed that school records are "open" records and may be reviewed by anyone having access to school records and may be shared without my knowledge or permission. I have the right to review all school records and have an opportunity for a hearing to challenge the content of the records. For the purposes of Informed Consent, all blank areas MUST be completed before the client or legal guardian signs the authorization.

____
Client/Parent/Guardian Signature

____________________ ____________________
Client/Parent/Guardian Printed Name Date

____________________ ____________________
Witness signature Date