Rachel Wolfield, LCSW-R
499 Glen Street, Glens Falls, NY 12801
Phone: 518-798-9187 Fax: 518-223-0567

RELEASE OF INFORMATION/AUTHORIZATION

Client Name: ____________________________________ **DOB:** ____/____/____

I do hereby consent and authorize Rachel Wolfield, LCSW-R to exchange my protected health information or the protected health information of my child (whichever is applicable) to the person(s) designated below (i.e., physician, pediatrician, school official, relative, etc.):

Name:
____

Address:
____

Telephone:
____

Fax:
____

☐ I do not wish for my primary care physician or my child's pediatrician (whichever is applicable) be contacted.

By signing below, I am authorizing the exchange of information between providers related to my (or my child's) diagnosis, treatment, and progress for the purpose of coordinating treatment.

This authorization will remain in effect for one year from the date below or until treatment is terminated. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Rachel Wolfield, LCSW-R. However, I understand that my revocation will not be effective to the extent that Rachel Wolfield, LCSW-R has taken action in reliance on the 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.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this information and no longer protected by HIPAA or any other federal or state law.

I understand that Rachel Wolfield, LCSW-R 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 Client/Parent/Guardian **Date**

____

Printed Name of Client **Relationship to Client**