567 Park Avenue
Suite 204
Scotch Plains, NJ 07076
(908) 242-3634
www.BraveMindsNJ.com

Brave Minds Psychological Services LLC
Authorization for Use and Disclosure of Protected Health Information

This form provides authorization to **Brave Minds Psychological Services LLC** to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I, ___________________________________, (client's name _______________ date of birth: ___________) authorize **Brave Minds Psychological Services LLC** to disclose to and/or obtain from:

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The following information:
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The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization.

Purpose of Information to be Disclosed:
If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the purpose below, the purpose shall be stated as "at the request of the individual."
___Assessment ___Progress in Treatment ___Diagnosis
___Discharge/Treatment Summary ___Treatment Plan or Summary
___Participation in Treatment ___ Other Purpose_________________________________

This authorization shall expire upon the earlier of (i) ____ days from the date of this request or (ii) the following date ______________ or (iii) the occurrence of the following:
____.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Practice's Privacy Officer at **Brave Minds Psychological Services LLC, 567 Park Avenue, Suite 204, Scotch Plains, New Jersey 07076**.

I understand that if my records contain information about HIV/AIDS status, I authorize **Brave Minds Psychological Services LLC** to release such information as part of my medical record.

I understand that a revocation is not effective to the extent that **Brave Minds Psychological Services LLC** has taken action in reliance on this authorization or if this authorization was

obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that **Brave Minds Psychological Services LLC** will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

______________________________	____________________
Client's Name (Print)	Date of Birth
______________________________	____________________
Signature of Client (All clients Age 14+)	Date
______________________________	____________________
Name of Personal Representative or Guardian (if needed)	Relationship to Client
______________________________	____________________
Signature of Personal Representative or Guardian	Date

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Printed Name of Therapist