0. Release of Information Current (Update 2025)

Authorization for Use and Disclosure of Protected Health Information

Client Full Name:

Client Date Of Birth:

1. Brave Minds Psychological Services LLC is authorized to disclose to and/or obtain Protected Health Information from:

(Please list all people/organizations you want us to be able to connect with)

Name and phone number/address:

Name and phone number/address:

Name and phone number/address:

Name and phone number/address:

The disclosure of any part of the medical record deemed to be “psychotherapy notes” will require a separate authorization.

2. Purpose of Information to be Disclosed (Why do you want us to share information?):

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
- [ ] Participation in Treatment
- [ ] Billing and Payment (includes Diagnosis and Appointment Schedule) and Emergency Contact
- [ ] All of the above

Other Purpose:

3. Expiration (When would we stop sharing information?)

This authorization shall expire in 365 days OR upon written revocation OR the occurrence of the following:

4. Your Rights

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.

Today's Date:

Name of Therapist (select one):

- [ ] Alexandria Bleich, LPC
- [ ] Brianna Albanese, LAC
- [ ] Casey Conte, LCSW
- [ ] Claudia Salgado, LMFT
- [ ] Cristina Varriale, LAC
- [ ] Elaine Harrison-Yau, LCSW
- [ ] Fawn McNeil-Haber, PhD
- [ ] Jessica Pizzo, LCSW
- [ ] Kara Drake, Counseling Intern
- [ ] Kerry Isgur, LCSW
- [ ] Lauren Grossbach, LMFT
- [ ] Leah Behar, LCSW
- [ ] Lisa Weiss, LCSW
- [ ] Linda Farag, LSW
- [ ] Megan Herelle, LAMFT
- [ ] Victoria Forlenza, Counseling Intern

Print Name Parent/Guardian (if applicable):

Date:

Signature: