567 Park Avenue, Suite 204
Scotch Plains, NJ 07076

3322 Route 22 West, Suite 1401
Branchburg, NJ 08876

O: (908) 242-3634
Tax ID: 81-5115434
NPI: 1619414885

BRAVE MINDS
psychological services

Young Adult Contact Form

Client Full Name: _____Client Date Of Birth: _____

Contact Number: _____

What information may be left on the voicemail?

- ☐ Therapist Name and Number
- ☐ Appointment information
- ☐ Reason for call

Email Contact Release

Email address (For client portal correspondence and otherwise):

_____

- ☐ You may contact my email for scheduling purposes or to provide information
- ☐ I would like to receive Brave Minds e-newsletter with anxiety reduction techniques, parenting tips, and the latest happenings at Brave Minds via email.

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.

Brave Minds Psychological Services LLC is authorized to disclose to and/or obtain from the following parents/guardians/persons financially responsible:

Name, phone number and email 1):

_____

(Name, phone number and email 2 - if applicable):

_____

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Client Full Name & Date of Birth: _____

Purpose of Information to be Disclosed

Billing and Payment information (includes Diagnosis and Appointment Schedule) and Emergency Contact Other Purpose

You may elect disclosure of information for the following purposes

- ☐ Assessment
- ☐ Progress in Treatment
- ☐ Diagnosis
- ☐ Discharge/Treatment Summary

Expiration

This authorization shall expire in 365 days OR upon written revocation OR 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 PsychologicalServices 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.

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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: _____

Thank you for your information.

If applicable,

Guardian Name: _____

Guardian Relationship: _____

Guardian Signature: _____

Client (18+) Signature: _____

Today's Date: _____