HUDSON VALLEY CENTER FOR COGNITIVE THERAPY
421 North Highland Avenue • Upper Nyack, NY 10960
(845) 353-3399 • Fax: (845) 353-2272 • http://www.hvcct.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize HVCCT to obtain information from and release information to:

_____ _____
Person/Agency Telephone Number

The specific information to be disclosed is:

____ Diagnosis Only
____ Beginning and End Dates of Treatment
____ Psychological Assessment/Testing Information
____ Verbal/Written Communication Regarding Treatment
____ Termination Summary
____ Other (specify) _____

This information will be used for the following purpose(s):

____ Evaluation and Continuing Treatment
____ Coordination of Care
____ Educational Placement/Other Educational Purposes
____ Other (specify) _____

I understand that I have the right to revoke this authorization at any time. The revocation will not apply to any information that has already been released in response to this authorization. This authorization will in expire one year from the date of the signature below and may be used until such time for either a one time release or periodic release of information. I also understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have the right to receive a copy of this authorization upon my request. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by the federal privacy rules or by New York law.

_____ _____
Signature of Patient or Legal Guardian Date

_____
If Signed by Legal Guardian, Relationship to Patient

_____ _____
Signature of Witness Date

_____ _____
Signature of HVCCT Therapist Releasing Information Date