Eileen Moran, LCSW **Eileenlcsw@gmail.com**
1129 Northern Boulevard **516-737-1241**
Manhasset, NY 11030

I, _____, authorize Eileen Moran, LCSW to disclose to and/or obtain from: _____ the following information for my minor child_____, whose date of birth is_____:

Description of Information to be Disclosed
(Initial each item to be disclosed)

_____
Assessment

_____ Diagnosis
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information

_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____
_____Other_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____
Signature of Patient/Client Date

_____
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

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_____ _____
Signature of Staff Witness Date