Richard E. Madden, PhD, LCSW

125 Wolf Road, Suite 210, Albany, NY 12205

Authorization for Disclosure of Personal Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the disclosure of the above named individual's personal health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: Richard E. Madden, PhD, LCSW Address: 125 Wolf Road, Suite 210, Albany, NY 12205

3. The type and amount of information to be disclosed is as follows: (include dates where appropriate).

__X__ Psychosocial Assessment
_____ Diagnosis, Treatment Plan
_____ Treatment Progress
_____ Recommendations
_____ Discharge Summary

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. *This information may be disclosed to and used by the following clinician/medical practice for the purpose of:*
COORDINATION OF MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

Name: _____Tel #: _____

Address: _____Fax #: _____

6. I understand that I have a right to revoke this authorization, in writing, at any time by sending notice to Richard E. Madden, PhD, LCSW. I understand that a revocation is not valid to the extent that action by Dr. Madden has already been taken in reliance upon the authorization, and that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary and that I need not sign this form in order to assure treatment. I understand that I have the right to inspect and copy this information and that any disclosure of information carries with it the potential for unauthorized redisclosure. If I have questions about disclosure of my health information, I can contact: Richard E. Madden, PhD, LCSW, PO BOX 280, HANNACROIX, NY 12087 or telephone (518) 225-7707.

8. A copy of this form shall have the same force and effect as the original.

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

NOTICE TO RECEIVING FACILITY/CLINICIAN: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state and federal law.