The Massler Center for Psychological Wellness, P.C.

127 East Mount Pleasant Avenue
Livingston, NJ 07039
&
49 Brant Ave., Suite 3
Clark, NJ 07066
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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME____________________________ ADDRESS____
S.S. #_____________________ DOB_________________ TELEPHONE #______________________________

I hereby authorize the Massler Center for Psychological Wellness, P.C. to (please check) ___ RELEASE and/or ___ OBTAIN information from my record to:

NAME______________________________ TITLE:______________ TELEPHONE#________________________
ADDRESS____

For the purpose of: (Please check one)

___ Continued Treatment/Coordination of Care ___ Other (please specify)_____________________________

Description of information to be released: (Please check specific items)

___ Treatment Plan/Records ___Written/Verbal Communication ___ Medical Records ___ Student Records

___ Other (please specify) ____

If the requested portion of the record contains information pertaining the treatment or abuse, physical and/or mental illness, drug or alcohol treatment or contains HIV related information, I specifically authorize the release of such information by initialing one or both of the following:

________ I understand that if my record contains **information concerning the treatment for abuse, physical and/or mental illness or drug/alcohol treatment**, such information will be released pursuant to this consent.
________ I understand that if my record contains **confidential HIV related information**, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicated that a person has been potentially exposed to HIV.

Specifications of the date, or condition upon which this consent expires:____

I have the right to revoke this authorization in writing by sending a request to The Massler Center for Psychological Wellness, P.C, I understand that this authorization is voluntary and that I may refuse to sign this authorization. A copy of this authorization will be provided if requested.

I understand that after the Massler Center for Psychological Wellness, P.C. disclosed my health information, it may be subject to re-disclosure and, at that point, the information may no longer be protected by privacy laws or under the terms of this agreement.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below:

____ ______________________
Signature Date