Lindsey K. Robertson, MSSW, LCSW
Psychotherapist for Individuals, Children & Families
450 Springfield Ave, Suite 302
Summit, New Jersey 07901
RobertsonLCSW@gmail.com
917-671-8227

Client name _____ Date _____

Authorization for Use Or Disclosure Of Information

I, _____ (DOB :), hereby authorize Lindsey Robertson, LCSW at 450 Springfield Avenue In Summit, NJ to:
____ **Obtain from the following protected health information, and/or**
____ **Disclose to the following protected health information to:**

Name of Receiver: _____

Address of Receiver: _____

_____

Phone # of Receiver _____ Fax: _____

I understand that the specific type of information to be disclosed is information from my records relating to my history, diagnosis, prognosis, or treatment, specifically,

_____ Treatment Plan/Summary
_____ Mental Status
_____ Medical Information
_____ Psychological Report/Eval
_____ Psychiatric Evaluation
_____ Educational Eval/Information
_____ Other (specify)

_____ Progress in Treatment
_____ Neurological Evaluation
_____ Current Treatment Update
_____ Med Management Update
_____ Discharge/Transfer Summary
_____ Final/Closing Summary

_____ Diagnosis
_____ Assessment
_____ Psychosocial Assessment
_____ Presence/Participation in Treatment
_____ Continuation of Care Plan
_____ Demographic Information

This protected health information is being used or disclosed for the following purposes (check all that apply):
_____ To coordinate care
_____ To complete client assessment/treatment planning
_____Other, specify _____
_____

- Unless sooner revoked, this authorization expires on the following date _____ or as otherwise indicated: _____
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Lindsey Robertson, LCSW. I understand that a revocation is not effective to the extent that Lindsey Robertson, LCSW has relied on the use or disclosure of the protected health information.
- Lindsey Robertson, LCSW will not condition my treatment on whether I provide authorization for the requested use or disclosure; however, it has been explained to me that failure to sign this consent form may restrict the collaboration of care as it pertains to my case.
- I understand that: I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights); I have the legal right to have specific information within those records withheld; I have the right to receive a copy of this authorization for my records.
- Furthermore, unless otherwise requested (in writing), the disclosed information will be made in a manner that Lindsey Robertson, LCSW deems appropriate and consistent with applicable law, including but not limited to, verbally or paper/electronic format.
- I understand that it is possible that the PHI that is disclosed pursuant to this authorization may be redisclsoed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more stringent than HIPAA and provides additional privacy protections.

_____ _____
Client 1 Date

_____ _____
Client 2 Date

_____ _____
Parent/Legal Guardian or Personal Representative 1 Date

_____ _____
Parent/Legal Guardian or Personal Representative 2 Date

_____ _____
Signature of Clinician Date