2017

AUTHORIZATION FOR RELEASE OF INFORMATION

I/ We authorize Thelma A. Costello, 125 Wolf Road, Albany, N.Y. 12203 to release and disclose information from the clinical record of :

_____ (_____)

(Name of client / recipient of mental health services) (Date of birth)

to allow such information to be inspected and copied by:

_____

(Facility Provider)

_____

(Address)

Nature of information to be disclosed: _____

(State specific nature of information to be disclosed)

For the purposes of: _____

(State specific nature of information to be disclosed)

I understand that have the right to revoke this authorization in writing at any time by sending notice to Thelma A. Costello , MS, LMHC. I understand that a revocation is not valid to the extent that Thelma A. Costello, MS, LMHC has acted in reliance on such authorization. This authorization is valid until 12/31/2017. It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify if any): no information released and/or a copy of this release shall have the same force and effect as the original.

_____ _____

(client signature 12 years or older) (Date) (Parent / guardian signature) (Date)

_____ _____

(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and if that occurs, the information may not be protected by Federal Law.