

David Morgan, LCSW-R, CAMF
Long Island Anger Management
215 Hallock Road, Suite 6A
Stony Brook, NY 11790
P: (631) 675-6306 F: (631) 675-6306

HIPAA AUTHORIZATION FORM

Name of Client: _____ DOB: _____

I authorize (name, address, phone number) _____

to disclose to and/or obtain from David Morgan, LCSW-R, the following information:

- Relevant Clinical Information Presence /Participation in Treatment Diagnosis
 Current Treatment Update Continuing Care Plan 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. If other purpose, please specify: _____

Revocation:

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to David Morgan, LCSW-R to the office address above. 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:

This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

Conditions:

I further understand that David Morgan, LCSW-R will not condition my treatment on whether I give authorization for the requested disclosure.

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, paper format or electronically.

Re-Disclosure:

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part2. Other types of information may be re-disclosed by the recipient of the information in the following circumstance:

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

Signature of Client Date

Signature of Parent/Guardian Date

Witness

Date