Kimberly Pillsbury, MA, LPC, LCADC, ACS, NCC, LLC

Psychotherapist

316 Broad Street, Suite 4
Red Bank, NJ 07701
732-737-1224

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Name: _____ **Date of Birth:** _____

I hereby authorize Kimberly Pillsbury, LPC, LCADC, to exchange protected health information below with these parties:

_____

Requested information:

I authorize the exchange of the following types of records, created from _____ to _____:
(date) (date)

___ Attendance (appointments scheduled and met; dates of service) ___ Treatment plan

___ Safety concerns (level of danger to self or others) ___ Treatment notes

___ Alcohol and other drug use ___ Academic related issues ___ Billing records

___ Written mental health records ___ Other: _____

The purpose of the Requested Use or Disclosure is:

___ At the request of the patient ___ For continuity of care ___ For coordination of care

___ To address academic concerns ___ Other: _____

I understand that:

1. My authorization of disclosure of this information can be revoked by providing a dated and signed written revocation to Kimberly Pillsbury. However, mental health information disclosed before the receipt of my written revocation may be used for the purposes stated above.
2. This authorization applies only to the disclosure of mental health information which exists as of today.
3. Information disclosed to a healthcare provider or health plan, in accordance with my authorization, cannot be further disclosed by the recipient without my consent, unless otherwise authorized by law.
4. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
5. Within the provisions of the Mental Health Information Act, I have a right to review the mental health information contained in my record.
6. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment.

Expiration Date: This authorization expires in 60 days from today's date, or this earlier date:

_____ , or when the following event occurs: _____

_____	_____	_____
Signature of Patient	Date	Printed Name
_____	_____	_____
Signature of Personal Representative	Date	Printed Name