HUDSON VALLEY CENTER FOR COGNITIVE THERAPY
421 North Highland Avenue • Upper Nyack, NY 10960
(845) 353-3399 • Fax: (845) 353-2272 • http://www.hvcct.com

## AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize HVCCT to obtain information from and release information to:

Person/Agency: Telephone Number:

The specific information to be disclosed is:

- Diagnosis Only
- Beginning and End Dates of Treatment
- Psychological Assessment/Testing Information
- Verbal/Written Communication Regarding Treatment
- Termination Summary
- Other (specify)

This information will be used for the following purpose(s):

- Evaluation and Continuing Treatment
- Coordination of Care
- Educational Placement/Other Educational Purposes
- Other (specify)

I understand that I have the right to revoke this authorization at any time. The revocation will not apply to any information that has already been released in response to this authorization. This authorization will in expire one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information. I also understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have the right to receive a copy of this authorization upon my request. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by the federal privacy rules or by New York law.

By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

Signature of Patient or Parent/Legal Guardian If under 18): Date:

Printed Name:

Signature of HVCCT Therapist Releasing Information: Date:

Printed name of Therapist: