Consent for Release of Information

I authorize : Jill Fellner LCSW, LLC
466 Kinderkamack Rd, Ste C.
Oradell, NJ 07649
201-749-0065

to release information from the records of _____
(patient's name and date of birth)

The information is to be released to _____
(person/organization)

_____
(address and telephone number)

for the purpose of_____

_____

The information to be released is _____

_____

I understand that this consent will expire upon my termination of treatment with Jill fellner LCSW, LLC. I have the right to change my mind regarding the release of information from my medical record at any time, unless such information has already been released. The undersigned understands the nature of the authorization and has been informed that he or she has the right to revoke consent at any time, by written communication with Jill Fellner LCSW, LLC.

Dated _____

Patient _____

Parent/Legal Guardian (when applicable) _____

Therapist's Signature _____

NOTE to Recipient of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal and State law. Federal and State regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Anyone who receives information covered by these regulations, whether obtained legally, or not, is prohibited from using that information for any criminal or civil investigation, or prosecution of the patient.

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.