Gershon Psychological Associates, LLC

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AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Patient Name: _____Date of Birth_____
(hereinafter "Patient") hereby authorize **Gershon Psychological Associates, LLC** , (hereinafter "Provider") to obtain/disclose mental health treatment information and records obtained in the course of treatment of Patient, including, but not limited to, therapist's diagnosis of Patient,
TO___ and/or FROM___:

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Gershon Psychological Associates, LLC at 400 Bald Hill Rd, Suite 530 Warwick, RI 02886 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

□ Treatment Planning
□ Continuity of Care
□Other:_____

The specific uses and limitations of the types of medical information to be discussed are as follows:

□ Progress Notes
□ Verbal/ Written Communication
□ Psychological Evaluations
□ Medical History and Evaluations
□ Educational Records
□Other _____

Dates of Treatment: _____

□ Do not release my information at this time

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Rhode Island law may protect such information.

Patient's signature (or patient representative):_____
Date:_____ Valid until:_____