Elizabeth Lacy, LCSW
110 West 96 Street, 1D, NY, NY 10025 www.elizabethlacy.com ph.845.489.8700 f. 845.875.9867

Authorization for Release of Information Form

I, _____, hereby authorize Elizabeth Lacy, LCSW to release/receive the health care information described below to/from: Name, address and phone of person receiving/releasing information:

_____

_____

_____

This request and authorization applies to the following protected healthcare information:
__ Psychosocial Assessment/History __ Other relevant Clinical Data
__ Progress Notes__ Emergency Clinical Information __ Treatment Plan__
Other_____

This request and authorization will remain in effect unless revoked or unless designated specifically here: Date of Expiration_____

I understand that, except for action already taken, I may revoke this authorization in writing at any time by delivering or sending written notification to my therapist at the above address.

I also understand that I have a right to receive a copy of this authorization and that a copy be maintained in my record. I understand that I have a right to refuse to sign this authorization.

The information disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by state and federal privacy laws. Recipient may not redisclose HIV-related information unless permitted to do so by special release.

Please sign below to authorize the use or release of your personal health information for the reasons and the conditions established above:

_____
Patient Signature Date

_____
Witness Date

Part II

Cancellation
I hereby cancel my permission to release/receipt of information stated above

_____
Patient Signature Date

_____
Witness Date