Chelsea Place Psychological Services, PLLC

6 Chelsea Place Suite 202
Clifton Park, NY 12065
Phone: 518 982-1886
Fax: 518 734-0276

CONSENT TO OBTAIN/DISCLOSE INFORMATION

Patient Name_____ **Date of Birth**_____

I authorize Chelsea Place Psychological Services PLLC to:

___conduct an observation of my child
___obtain medical and/or academic information from
___give information to
___both obtain information from and give information to (Please list people we can get/give info. from/to):

_____

_____

_____

_____

for the purpose of developmental evaluation and/or treatment planning for the above patient. I understand that if this authorization is for the purpose of giving information, all diagnostic and therapeutic information may be included, with the following exception(s) (check as appropriate):

_____ no exceptions
_____ information on substance use and/or treatments
_____ specific diagnostic information (specify: _____)
_____ specific treatment information (specify: _____)
_____ other (specify: _____)

This authorization may be revoked at any time except to the extent that action has already occurred in reliance thereupon. This authorization shall be valid for (90) days unless otherwise specified.

Signature of parent/guardian_____ **Date**_____

Relationship to patient_____

Signature of witness_____

Print name of witness_____

Any redisclosure of medical record information by the recipient(s) is prohibited in connection with the further care of the patient and used solely for his or her benefit. If drug abuse or alcohol records are involved here, this information is disclosed from records from which confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibit redisclosure without specific written consent, of the persons to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information will not be sufficient for this purpose.