BOCES EMPLOYEE ASSISTANCE PROGRAM

Ronkonkoma: 289-0480 · Commack: 218-5445 · Hampton Bays: 728-2008

Authorization for Release of Health information Pursuant to HIPAA

Client Name	Date of Birth
Client Address	

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In Accordance with New York State Law and privacy Rule of the Health insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes and **CONFIDENTIAL HIV* RELATED INFORMATION** *unless otherwise specified below*.

I hereby authorize the release of protected health information:

FROM: BOCES Employee Assistance Program (EAP), ________________________________
(Counselor Name)
5018 Expressway Drive South
Suite 204
Ronkonkoma, NY 11779
(631) 289-0480

TO: Name: ________________________________
Title: ________________________________
Address: ________________________________
Phone: ________________________________

I understand and acknowledge that this disclosure may include **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, or **HIV/AIDS related information**.

Information to be disclosed: Related to specific reasons client is seeking therapy. Including relevant background information about presenting problem.
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Specific Need for Disclosure: To help client obtain an appointment with a qualified mental health professional for treatment.
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I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that this action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not disclose my medical record to another party without further written consent.

I will not hold BOCES EAP or the above named counselor liable for any injury, whether mental or physical resulting from any misunderstanding of information in the released information as a result of my not asking for clarification of the information released.

Date:	Client Signature:
Date:	Witness Signature: