

Daniel Menely, LMHC
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AUTHORIZATION/CONSENT FOR DISCLOSURE OF CLIENT RECORDS OR COMMUNICATION

I hereby authorize Daniel Menely, LMHC, to disclose information and/or receive information to the extent or nature indicated to/from:

Recipient Name/Address: for

the purpose of .

The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose and may include the following items **(unless crossed out by me)**

- Drug and/or alcohol abuse information
- Information regarding Immunodeficiency virus (HIV) including laboratory test results
- History and physical examinations
- Psychological & neuropsychological test results
- Raw data from psychological and neuropsychological tests
- Clinical notes, including correspondence and billing/insurance information
- Psychological and neuropsychological reports
- Other:

regarding: **(Patient/Client Name)** **(DOB)** .

I understand that in New York the communications between clients and educators/mental health practitioners are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately and will expire after 90 days from the date of signature. However, I also understand that I may revoke my consent before 2 days elapse by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connection with the aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is released, there is potential for that information to be re-disclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original.

I hereby release **Daniel Menely** from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Signed:
Client/Patient/Parent (in case of minor)

Date: