Westfield
MENTAL HEALTH SPECIALISTS, LLC
547 East Broad Street, Second Floor, Westfield, New Jersey 07090
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Authorization to Release Information

Regarding
Patient Name:_____ Date of Birth:_____

Address:_____ Phone:_____

To
Name of Agency: _____

Address:_____

Phone: _____Fax: _____

Release of Medical/Mental Health Records
My signature below authorizes Westfield Mental Health Specialists, and the agency or professional to whom this form is addressed, to disclose medical/mental health information and records regarding the individual listed above. This consent shall operate as a complete release of liability to WMHS and to its providers for the release of information as specified below. This release is to be limited to the specified reports within the specified dates of treatment indicated below.

☐ currently OR ☐ on or about the following dates _____

Purpose of Disclosure:

☐ Request of Individual or Parent/Legal Guardian ☐ Other _____

Information to be used/released:

☐ Medical History and Examinations
☐ Medication Records
☐ Psychiatric Evaluations / Psychological Testing
☐ Drug/Alcohol Treatment Records
☐ Sexually Transmitted Infection/HIV/AIDS
(*if your information contains HIV/AIDS related information you must check this box*)
☐ Genetic
☐ Education – IEP/School Records
☐ Verbal Communication – No Restrictions
☐ All information, no restrictions
☐ Other: _____

Unless otherwise revoked by me, this Authorization is valid for 1 year from the date below. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this Authorization. Once the requested protected health information is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient rediscloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Westfield Mental Health Specialists from all liability should this information be received by someone other than the above-intended recipient.

_____ _____ _____
Patient Signature Date Signature of Witness

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Signature of authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative | Relationship | Date | Signature of Witness

Notice to Recipient of Information
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and New Jersey Public Law 303. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and New Jersey Public Law 303. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.