Brina Teitz Mental Health Counseling
(347) 860-9099|brinateitzLMHC@gmail.com

Authorization for the Disclosure of Confidential Information

Name: _____ DOB: _____

Residing at: _____
(Address)

I hereby authorize Brina Teitz, LMHC, to (check one or both of the following):

▫ Obtain information from:
▫ Release information to:

Name of Facility: _____
Name of Individual (if applicable): _____
Address:_____
Phone:_____Fax:_____

_____ I authorize minimum necessary amount of information be disclosed via e-mail to:
(Initial) _____.

For the purposes of treatment planning and/or _____related to (check one or more):
(Other)

▫ Child Protective Services
▫ Counseling
▫ Diagnostic Interview
▫ Education or Child Study Team Evaluation
▫ Legal Records/Status
▫ Medical Records _____
▫ Parole/Probation
▫ Psychiatric Examination
▫ Psychological Evaluation
▫ Psychosocial Assessment
▫ Substance Abuse Assessment and Treatment
▫ Other (Specify) _____

Disclosure Policy:
I hereby authorize the release of the above information which is confidential and protected from further disclosure, with the understanding that no information will be released which Brina Teitz Mental Health Counseling considers not to be in my best interest. I also understand that I have the right to cancel this permission to release information at any time before it is released and that my consent to release information will expire 1 year from this date if not acted upon prior at that time. If I experience discrimination because of release of HIV confidential information, I can call the NYS Division of Human Rights. This authorization releases Brina Teitz Mental Health Counseling and its clinicians from any and all liability arising from the release of this information.

Signature_____ Date _____

Relationship to Patient (Minor)_____

Signature of Therapist _____ Date_____

Revocation of Consent: I hereby revoke authorization to disclose information to the above named facility.
Signature_____ Date_____
Relationship to Patient (Minor)_____