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914-907-2600

Patient Name _____

Address _____

I hereby give permission to the following person(s) to disclose any information or clinical data that will contribute to my treatment planning or coordination of services. I do so voluntarily in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

1. Name _____ Telephone _____
Relationship to Patient _____

2. Name _____ Telephone _____
Relationship to Patient _____

3. Name _____ Telephone _____
Relationship to Patient _____

4. Name _____ Telephone _____
Relationship to Patient _____

5. Name _____ Telephone _____
Relationship to Patient _____

Patient Signature

Date

Signature of Parent or Guardian if pt under 18

Date

Clinician

Date