



## Demographic and Insurance Information

**\*\*\*Please complete all questions on both pages of this form\*\*\***

Date	Social Security Number
------	------------------------

### Demographic Information- Please Print

First Name	Middle	Last Name
Address		
City	State/ZIP	Home Phone (   )
Cell Phone (   )	Work Phone (   )	
<b>OK to leave:</b> Voicemail at home? Yes___ No___ Voicemail at work? Yes___ No___ Voicemail on cell phone? Yes___ No___	<b>OK to leave a message with a family member?</b> Yes___ No___ Family member's name(s): _____	
Email Address:		
Date of Birth ____/____/____	Age:	Gender: Male____ Female____

### PARENT INFORMATION

Parent(s) name(s):	Custodial Parent:
Is someone other than the above legally responsible for your child? (please check one) Yes____ No____ If yes, Legal guardian name(s): _____	<b>Type of custody:</b> (please check one) Sole physical and sole legal____ Sole physical and joint legal____

### INSURANCE POLICY INFORMATION

Insurance Company/HMO	Patient ID #/Member ID
-----------------------	------------------------



<b>Group #</b>	<b>Policy Holder's Name</b>
<b>Policy Holder's DOB:</b> _____  <b>Policy Holder's SS#:</b> _____	<b>Claims Mailing Address:</b>
<b>Phone</b>	<b>Relationship to Policy Holder:</b> (ex. Spouse, child, guardian, etc.)

**Secondary Policy Information (if applicable)**

<b>Insurance Company/HMO</b>	<b>Patient ID/Member ID</b>
<b>Group Number</b>	<b>Policy Holder's Name</b>
<b>Policy Holder's DOB</b>	<b>Relationship to Policy Holder</b>
<b>Claims Mailing Address</b>	<b>City</b>
<b>State/ZIP</b>	<b>Phone</b>

**Pharmacy Information**

<b>Pharmacy Name</b>
<b>Address</b>
<b>Phone Number</b>

**Signatures**

_____ <b>Client or Parent/Legal Guardian Signature</b>	_____ <b>Date</b>
_____ <b>Responsible Party Signature</b>	_____ <b>Date</b>
_____ <b>Print Name</b>	



**OFFICE COPY**

## **AUTHORIZATIONS AND AGREEMENTS with GENPSYCH**

The paragraphs below contain several agreements.

Please read carefully and sign the *Client Copy* and the *Office Copy*

Client Name: \_\_\_\_\_

### Medical Insurance

I authorize the medical insurance company to pay directly for GENPSYCH services. I, however, understand that the person who signs below is responsible for all my fees, including any fees not paid by the insurance company.

### Release of Information

I authorize GENPSYCH to release/receive verbal and written information about me to/from the medical insurance company and the referring physician. This authorization will end if I give written instructions to GENPSYCH to that effect, which I may do at any time.

### CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we had to implement an appointment cancellation and “no-show” policy. This policy enables us to better utilize available appointments for our clients in need of medical care. Please be courteous and call the appropriate office in which you scheduled your appointment promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require to that you call at least 24 hours in advance, and calling early in the day I appreciated. If you do not reach the receptionist, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave a phone number and let us know the best time to return your call.

A \$100.00 fee will be applied to your account for cancellations not made in the 24 hour time from or “no-shows.”



*Please note: For those clients who may be receiving GENPSYCH,PC transportation services, as consideration for our lengthy van waiting list, a fee of twenty-five dollars (\$25) will be charged for every cancellation of transportation without proper notice.*

**CLIENT COPY**

## **AUTHORIZATIONS AND AGREEMENTS with GENPSYCH**

The paragraphs below contain several agreements.

Please read carefully and sign the ***Client Copy*** and the ***Office Copy***

Client Name: \_\_\_\_\_

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*Please note: For those clients who may be receiving GENPSYCH, PC transportation services, as consideration for our lengthy van waiting list, a fee of twenty-five dollars (\$25) will be charged for every cancellation of transportation without proper notice.*

***FOR PROGRAM ONLY***

## **NOTICE OF CONSUMER FINANCIAL RESPONSIBILITY**

### **Billing and Insurance**

As a courtesy to our consumers, Genpsych, PC will verify your mental health benefits with your insurance carrier. In order to do so, we must obtain a copy of your insurance card and obtain the name, address and birth date of the subscriber. The information that we receive is not a guarantee of payment. We recommend that you reference your mental health benefit policy or consult your carrier directly with questions regarding benefits and participation.

In addition, Genpsych, PC will bill your insurance carrier for services provided. All co-payments are due at the time of service. Co-insurance, deductible and any outstanding balances will be due upon receipt of our billing invoice.

### **Payment Options**

Genpsych, PC accepts cash, checks, money orders and major credit cards. Monthly payment plans may be arranged by calling the Billing Department at (908) - 526-8370.

### **Returned Checks**

A fee of \$35.00 will be added to your balance due for all returned checks

### **Self-Pay**

To assist our self-pay consumers, Genpsych, PC has developed a Self-Pay Fee Schedule Discount Program. Designed to help defray the cost of medical care for the uninsured, the program offers a discount to uninsured consumers only. For more information, please call the Billing Department at (908) 526-8370.

### **Estimated Fees**

The fees associated with your care may include but are not limited to the following service:

- \$100.00- Medication Management
- \$350.00- Psychiatric diagnostic evaluation exam
- \$525.00- Intensive Outpatient Program Per Diem
- \$800.00- Partial Hospitalization Program Per Diem

The self-pay fees may include but are not limited to the following service:

- \$100.00- Medication Management
- \$350.00- Psychiatric diagnostic evaluation exam
- \$195.00- Intensive Outpatient Program
- \$295.00- Partial Hospitalization Program

### **Collections**

Genpsych, PC will make every effort to assist consumers with meeting their financial obligations. However, in the event that the consumer does not respond to our billing invoices or neglects to make arrangements, we reserve the right to transfer the outstanding balance to a collection agency. We also reserve the right to report delinquent accounts to credit bureaus and charge applicable collections agency fees directly to the consumer.

**I understand and agree to the above**



Patient Name (Print) \_\_\_\_\_

Patient or Parent/Legal Guardian Signature: \_\_\_\_\_  
 \_\_\_\_\_

Date: \_\_\_\_\_

**EMERGENCY CONTACT RELEASE**

I authorize Genpsych to contact the following person(s) in the event of an emergency. Please provide ***at least one*** emergency contact.

\*please fill out a release form for all emergency contacts identified below.

EMERGENCY CONTACT(S)

_____	_____	_____
<b>Name</b>	<b>Relationship</b>	<b>Phone Number</b>
_____	_____	_____
<b>Name</b>	<b>Relationship</b>	<b>Phone Number</b>
_____	_____	_____
<b>Name</b>	<b>Relationship</b>	<b>Phone Number</b>

I understand that this request will remain in effect until I am discharged from Genpsych PC unless I submit a written request for a change.

Client Name: (Please Print): _____
Client Signature: _____
Date: _____



**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (EMERGENCY CONTACT)**

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_  
 I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)  
 Psychiatric Evaluation       Therapy Notes       Treatment Plan(s)  
 Substance Abuse Evaluation       Substance Abuse Treatment Information       HIV/AIDS information  
 Medication Logs       Toxicology Results  
 Other:(please define information to be released) \_\_\_\_\_  
 \*\*\*\* Marketing purposes (please define the type of information that may be released and how it may be used) \_\_\_\_\_

"Marketing" is defined as "any communication about the organization, its products or services that encourages recipients to purchase or use the product or service."

\*\*\*\* GenPsych, its employees, and patients are strictly prohibited from receiving any remuneration by GenPsych or its affiliates as a direct result of this release. However release of protected health information for marketing purposes may encourage recipients' use of the organization's products or services.

\*\*\* Pursuant to NJAC 13:35-6.5, GenPsych reserves the right to charge \$1.00 per page for medical record reproduction, or \$100.00 for the entire record, whichever is less. If the record requested is less than 10 pages, the cost for the record reproduction may be up to \$10.00 to cover postage and the miscellaneous costs associated with the record retrieval.

I understand and authorize the exchange of information as requested above. I also understand that this release will remain in effect until \_\_\_\_\_ or until I am discharged from GenPsych,PC.

I understand that I may revoke this authorization in writing, which will take effect on the date it is received, except to the extent that GenPsych has already taken action in reliance upon my authorization, or as set forth by GenPsych's Notice of Privacy Practices.

I understand that if the above-named person or entity is not a health care provider or part of a health plan covered by federal privacy regulations and this form authorizes the release of my **health** information, my **health** information may be re-disclosed by the person or entity I have named above and will no longer be protected by these regulations. However, the person or entity named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that if I refuse to sign this form, GenPsych will not disclose my information to the person or entity named above, unless otherwise required by law. Furthermore, I understand that GenPsych will not condition any treatment or services on my signing this form.

Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

\*If Client is aged 14-17, both client and legal representative must sign release form.

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (EMERGENCY CONTACT)**

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_  
 I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:



Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)  
 Psychiatric Evaluation  Therapy Notes  Treatment Plan(s)  
 Substance Abuse Evaluation  Substance Abuse Treatment Information  HIV/AIDS information  
 Medication Logs  Toxicology Results  
 Other:(please define information to be released) \_\_\_\_\_  
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### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (EMERGENCY CONTACT)

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)  
 Psychiatric Evaluation  Therapy Notes  Treatment Plan(s)  
 Substance Abuse Evaluation  Substance Abuse Treatment Information  HIV/AIDS information  
 Medication Logs  Toxicology Results  
 Other:(please define information to be released) \_\_\_\_\_  
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Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

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## **INFORMED CONSENT FOR TREATMENT**

I, \_\_\_\_\_ (print name of client), agree and consent to participate in behavioral health care services offered and provided by GENPSYCH, PC, behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the client. I understand that these services may include individual, group, and/or family therapy, medication management, and urine, blood, or other tests for substances. If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.



Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

### **Notice of Clinical Supervision**

It is the policy of Genpsych to fully disclose the licensure status of therapists that individuals may work with individually or within a group setting. NJ Jersey law mandates that partially licensed therapists practice under the supervision of fully licensed therapists. Genpsych conducts an extensive qualification review of all staff and ensures that our staff practices in full compliance with New Jersey law.

- Please note that the following clinical supervision is conducted as required by New Jersey law. As defined by the NJ Division of Consumer Affairs, the state agency responsible for licensure, a “Qualified Supervisor” is an individual who holds a clinical license to provide mental health counseling services for a minimum of 2 years (obtaining at least 3,000 hours work experience subsequent to holding the license in a minimum of 2 years but no more than 6 years) in the state where the services are being provided, and who has a Clinical Supervisor’s Certificate, or is designated as an Approved Clinical Supervisor by the respective healthcare licensing board, or has completed a minimum of three graduate credits in clinical supervision from a regionally accredited institution of higher education.

Intern is a student currently enrolled in an accredited Master’s Program for Counseling or Social Work who practices under the supervision of a fully licensed practitioner-either a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW).

Licensed Associate Counselor (LAC) is a Master’s level practitioner who practices under the supervision of a Licensed Clinical Social Worker (LCSW).

Licensed Social Workers (LSW) is a Master’s level practitioner who practices under the supervision of a Licensed Clinical Social Worker (LCSW).



Certified Alcohol and Drug Counselor (CADC) practice under the supervision of a Licensed Certified Alcohol and drug Counselor (LCADC).

Non-licensed Psychologist is a Ph.D. level practitioner who practices under the supervision of a Licensed Practicing Psychologist.

I, (Print Name) \_\_\_\_\_, acknowledge that I have received and understand Genpsych's Clinical Supervision Policy. I understand that I may address any questions or concerns with regard to a therapist's license status to my assigned therapist.

**By signing below you are acknowledging you have been informed of this information:**

\_\_\_\_\_  
Client Name \_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Parent /Guardian Signature \_\_\_\_\_  
Date

**GenPsych Adolescent Program  
Parental Informed Consent Procedures for Prescriptions**

Client Name: \_\_\_\_\_

GenPsych Provider (prescribers) may prescribe medications for your child. Below is a procedure delineating the mechanisms in place to ensure that you are fully informed about any and all medications prescribed for your child.

Please carefully read the procedure and indicate your agreement by signing below.

1. I understand that the prescriber will call me regarding any medications prescribed for my child or any significant dosage changes in medications currently prescribed.
2. I understand that a medication fact sheet and informed consent signature form will be provided.
3. I understand that it is my responsibility to read the fact sheet and contact the prescriber regarding any questions or concerns I may have about the medication(s).
4. I understand that I have the option not to fill the prescription or administer the medication to my child until all of my questions and concerns are satisfied.



5. I understand that by filling the prescription and administering the medication to my child, I am giving my consent for the medication and dose prescribed.
6. I agree to sign the informed consent form as soon as I receive it if I intend to fill the prescription.
7. If my child requires medication dosing while at the program, I understand that this will be closely supervised by a member of the medical or nursing staff. Further, I agree to bring the medication in to the program in the originally labeled prescription bottle and hand it in to a member of the staff for safe keeping.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Witness

### **PRIMARY CARE PHYSICIAN**

Please check the category below that specifies your child's current status regarding care by a primary care physician.

- My child has a primary care physician. I will provide GenPsych Adolescent Program with their contact information so they may collaborate with the primary care physician in the care of my child. \*a release form must be filled out in order for GenPsych Adolescent Program to contact them.
- I have a primary care physician but I do not want GenPsych Adolescent Program to collaborate with them in the care of my child.



- I do not have a primary care physician and I need assistance finding one.

\_\_\_\_\_

Patients Name

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

Date

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (PRIMARY CARE PHYSICIAN)**

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)

- Psychiatric Evaluation       Therapy Notes       Treatment Plan(s)  
 Substance Abuse Evaluation       Substance Abuse Treatment Information       HIV/AIDS information  
 Medication Logs       Toxicology Results  
 Other:(please define information to be released) \_\_\_\_\_  
 \*\*\*\* Marketing purposes (please define the type of information that may be released and how it may be used) \_\_\_\_\_

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I understand and authorize the exchange of information as requested above. I also understand that this release will remain in effect until \_\_\_\_\_ or until I am discharged from GenPsych,PC.

I understand that I may revoke this authorization in writing, which will take effect on the date it is received, except to the extent that GenPsych has already taken action in reliance upon my authorization, or as set forth by GenPsych's Notice of Privacy Practices.



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Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

\*If Client is aged 14-17, both client and legal representative must sign release form.

### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (THERAPIST)

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)

- \_\_\_\_\_ Psychiatric Evaluation      \_\_\_\_\_ Therapy Notes      \_\_\_\_\_ Treatment Plan(s)
- \_\_\_\_\_ Substance Abuse Evaluation      \_\_\_\_\_ Substance Abuse Treatment Information      \_\_\_\_\_ HIV/AIDS information
- \_\_\_\_\_ Medication Logs      \_\_\_\_\_ Toxicology Results
- \_\_\_\_\_ Other:(please define information to be released) \_\_\_\_\_
- \_\_\_\_\_ \*\*\*\* Marketing purposes (please define the type of information that may be released and how it may be used)

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Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

\*If Client is aged 14-17, both client and legal representative must sign release form.

### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (PSYCHIATRIST)



Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_  
I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)  
 Psychiatric Evaluation  Therapy Notes  Treatment Plan(s)  
 Substance Abuse Evaluation  Substance Abuse Treatment Information  HIV/AIDS information  
 Medication Logs  Toxicology Results  
 Other:(please define information to be released) \_\_\_\_\_  
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\*\*\* Pursuant to NJAC 13:35-6.5, GenPsych reserves the right to charge \$1.00 per page for medical record reproduction, or \$100.00 for the entire record, whichever is less. If the record requested is less than 10 pages, the cost for the record reproduction may be up to \$10.00 to cover postage and the miscellaneous costs associated with the record retrieval.

I understand and authorize the exchange of information as requested above. I also understand that this release will remain in effect until \_\_\_\_\_ or until I am discharged from GenPsych,PC.

I understand that I may revoke this authorization in writing, which will take effect on the date it is received, except to the extent that GenPsych has already taken action in reliance upon my authorization, or as set forth by GenPsych's Notice of Privacy Practices.

I understand that if the above-named person or entity is not a health care provider or part of a health plan covered by federal privacy regulations and this form authorizes the release of my **health** information, my **health** information may be re-disclosed by the person or entity I have named above and will no longer be protected by these regulations. However, the person or entity named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that if I refuse to sign this form, GenPsych will not disclose my information to the person or entity named above, unless otherwise required by law. Furthermore, I understand that GenPsych will not condition any treatment or services on my signing this form.

Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

\*If Client is aged 14-17, both client and legal representative must sign release form.

### **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (SCHOOL CONTACT)**

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_  
I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)  
 Psychiatric Evaluation  Therapy Notes  Treatment Plan(s)  
 Substance Abuse Evaluation  Substance Abuse Treatment Information  HIV/AIDS information



\_\_\_\_\_ Medication Logs \_\_\_\_\_ Toxicology Results  
\_\_\_\_\_  
Other:(please define information to be released) \_\_\_\_\_  
\_\_\_\_\_  
\*\*\*\* Marketing purposes (please define the type of information that may be released and how it may be used)

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I understand that I may revoke this authorization in writing, which will take effect on the date it is received, except to the extent that GenPsych has already taken action in reliance upon my authorization, or as set forth by GenPsych's Notice of Privacy Practices.

I understand that if the above-named person or entity is not a health care provider or part of a health plan covered by federal privacy regulations and this form authorizes the release of my health information, my health information may be re-disclosed by the person or entity I have named above and will no longer be protected by these regulations. However, the person or entity named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that if I refuse to sign this form, GenPsych will not disclose my information to the person or entity named above, unless otherwise required by law. Furthermore, I understand that GenPsych will not condition any treatment or services on my signing this form.

Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

\*If Client is aged 14-17, both client and legal representative must sign release form.

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (REFERRAL)**

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)

\_\_\_\_\_ Psychiatric Evaluation \_\_\_\_\_ Therapy Notes \_\_\_\_\_ Treatment Plan(s)

\_\_\_\_\_ Substance Abuse Evaluation \_\_\_\_\_ Substance Abuse Treatment Information \_\_\_\_\_ HIV/AIDS information

\_\_\_\_\_ Medication Logs \_\_\_\_\_ Toxicology Results

\_\_\_\_\_  
Other:(please define information to be released) \_\_\_\_\_

\_\_\_\_\_  
\*\*\*\* Marketing purposes (please define the type of information that may be released and how it may be used)

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I understand and authorize the exchange of information as requested above. I also understand that this release will remain in effect until \_\_\_\_\_ or until I am discharged from GenPsych,PC.





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Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

\*If Client is aged 14-17, both client and legal representative must sign release form.

### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (OTHER)

Client's Name \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, request and authorize GenPsych, PC to release confidential healthcare information protected by U.S. Federal and State privacy laws to:

Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Purpose of release: \_\_\_\_\_

This request and authorization applies to: (check all applicable)

- \_\_\_\_\_ Psychiatric Evaluation      \_\_\_\_\_ Therapy Notes      \_\_\_\_\_ Treatment Plan(s)
- \_\_\_\_\_ Substance Abuse Evaluation      \_\_\_\_\_ Substance Abuse Treatment Information      \_\_\_\_\_ HIV/AIDS information
- \_\_\_\_\_ Medication Logs      \_\_\_\_\_ Toxicology Results
- \_\_\_\_\_ Other:(please define information to be released) \_\_\_\_\_
- \_\_\_\_\_ \*\*\*\* Marketing purposes (please define the type of information that may be released and how it may be used)

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Client Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

LegalRep's Signature\*: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Dated: \_\_\_\_\_

\*If Client is aged 14-17, both client and legal representative must sign release form.