Lenny Gallo, LCSW, LCADC, ACT, CBIT
LennyGalloLCSW.com
3 Overhill Rd.
Verona, NJ 07044-2815
Phone: 973-559-3668
Email: Lenny@LennyGalloLCSW.com

Authorization to Release Protected Healthcare Information records to Outside Persons and/or Entities
(Under Federal HIPAA Privacy regulations, therapy Notes require a separate, discrete authorization)

I **(Name) _____** hereby authorize:

Lenny Gallo, LCSW, LCADC, ACT, CBIT; 3 Overhill Rd., Verona NJ, 07044-2815; Phone: 973-559-3669; Email: Lenny@LennyGalloLCSW.com

to (□ **release to;** □ **obtain from;** □ **or exchange with);** from my, records, as specified below, to the following person(s): **Name/Title/Address, City, State, Zip:**_____

By: □ Written, to address above; □ Verbal, **(Phone #):** _____; □ Fax, (**Fax #):** _____

□ Email, (**E-mail Address):** _____

To be released:
□***Entire Mental Health Records and presence and participation in treatment. _____(Initial)**
*(may include ALL areas listed below and other information not listed here)

OR

☐ **Only release specified areas of Mental Health record as indicated below: _____(Initial)**

☐ Treatment Progress ☐ Treatment Plan or Summary ☐ Assessments ☐ Progress Notes (excludes psychotherapy note) ☐ Contact Log(s)

☐ Presence or Participation in Treatment ☐ Hospital Admission/Discharge ☐ Diagnoses ☐ Transfer/Discharge Summary/Aftercare Plan ☐ Legal including Family Court and DCP&P Involvement ☐ Medications ☐ Alcohol/Substance Use ☐ Medical Information ☐ HIV/Aids Status☐ Insurance Verification and Insurance Details.

☐ Other Not Listed:_____

This authorization for use/disclosure is for the following purpose(s)

_____

This authorization will otherwise expire in 90 days or the date listed. Specify Date: _____/____/_____

I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that action has already been taken on my authorization. I further understand that my decision to revoke must be made in writing. My written statement that I want to revoke/withdraw my authorization should be delivered to: **Lenny Gallo, LCSW, LCADC, ACT, CBIT, 3 Overhill Rd., Verona, NJ 07044-2815**.

Information under this release/exchange may be subject to re-disclosure by the recipient and no longer protected by the Federal regulations governing confidentiality, also known as the HIPAA Privacy Rule, but may be confidential under other Federal and State law.

Note to Recipient of Mental Health Records:
This information has been disclosed to you from confidential records protected by State Law. State Regulation (N.J.A.C. 10:37-6.79) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A General Authorization for the release of medical or other information is NOT sufficient for this purpose. This release shall be valid for a period no longer than 3 months unless otherwise specified.

Signature of Patient or Person authorized by law to give consent: If this authorization was signed by a personal representative on behalf of an individual, staff must verify his/her authority to act on behalf of the individual, and must set forth here (Attach any additional verifying information e.g. Divorce/Separation Decree/Guardianship/DCPP documents/Court Orders/Durable POA/Advance Directive):
Specify Type of Info: **_____**

Client Name: _____ DOB: _____

Signature: _____ Date: _____

Witness Signature: _____ Printed Name: _____

+++++++Updated and Effective as of 05/15/2020+++++++