CORA GOLDFARB
PSYCHOTHERAPY & PSYCHOANALYSIS

RELEASE OF INFORMATION FOR MINORS

Name of Patient: _____Date of Birth: _____/_____/_____

Name of Authorized Patient Representative:

_____

Relationship to Patient:

_____

I, _____, authorize Cora Goldfarb, LCAT, LP to discuss my child's (Name of Child: _____) information and treatment with the following parties:

1) Name: _____Affiliation: _____

2) Name: _____Affiliation: _____

Address: _____ Phone Number: _____

Address:_____PhoneNumber:_____

I authorize Cora Goldfarb, LCAT, LP to discuss any pertinent psychological and medical background information and current issues of concern with the named parties.

By signing below I acknowledge that the above information about the patient in my legal guardianship may be released, discussed, or disclosed. I understand that their records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to the office of Cora Goldfarb, LCAT, LP. Unless otherwise revoked, this consent expires in 12 months from the date signed. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may redisclose the information and it might not be protected by federal or state privacy regulations.

Signature of Authorized Patient Representative:

_____Date Signed: _____