DYNAMIC INTERVENTION WELLNESS SOLUTIONS
BEHAVIORAL HEALTH PROGRAM
CONFIDENTIAL INFORMATION CONSENT

I, _____ do hereby consent to and authorize an exchange of information by and between

Dynamic Intervention Wellness Solutions
1283 Route 311, Suite, Bldg. C
Patterson, NY 12563
Or
1207 Route 9, Suite 1A
Wappingers Falls, NY 12590
(845 702-1042

And

_____
_____
_____
_____

THE INFORMATION WHICH MAY BE DISCLOSED BY AND BETWEEN BOTH PARTIES IS:

( ) Presence in Treatment
( ) Diagnosis
( ) Psychosocial history/Diagnostic Summary
( ) Results of physical exams/lab results/medical diagnoses
( ) Description of progress in treatment/prognosis
( ) Treatment Plans
( ) Treatment Recommendations
( ) Discharge Summary
( ) Other:
_____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE:

( ) To provide ongoing treatment/Continuing care
( ) Obtain insurance/employment/government benefits
( ) To coordinate services with authorized school officials
( ) To coordinate treatment with my medical provider
( ) To coordinate treatment efforts with my family/significant other/concerned person
( ) To coordinate treatment and continuing care efforts with my employer
( ) To enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf.
( ) Other: _____

I understand my records are protected under the Federal Regulations governing confidentiality of mental health patient records, Title 42 CFR part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Article 27-F of the Public Health Law, Chapter 584, and cannot be disclosed without my written consent unless otherwise authorized in the regulations. Re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I may revoke this authorization at any time by a written notice except to the extent that such action has been taken in reliance on it. The authorization shall automatically expire 6 months from the date of its signing unless a specific date, event or condition upon which this consent expires is indicated below.

_____ _____
Event, Condition, or Date of Expiration

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Representative Date

_____ _____
Witness Date