#MoveUp Study
New York State Psychiatric Institute/Columbia U
1051 Riverside Dr, New York NY 10032
646-774-6965

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I _____, herby authorize and give my permission to the #MoveUp Study, New York Psychiatric Institute/Columbia University, 1051 Riverside Dr, New York, New York 10032 to release/receive information limited to the following specific items:

- Name and contact information of study participant
- Reason(s) for referral to treatment
- Date(s) of attendance at intake and/or treatment sessions
- Date(s) of clinic/agency visits
- Date(s) of treatment received
- Description of treatment received

I permit the confidential information to be released or received only to/from the following persons, agencies, or organizations:

_____

_____

I permit this confidential information to be released only for the following reasons and purposes:

- Data collection for the #MoveUp study
- Assistance with linkage and referrals for treatment

This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken; no further confidential information will be released without the execution of an additional written statement of consent.

_____ _____

Date of Permission Signature of Participant

_____

Signature of #MoveUp Staff