Osika & Scarano
PSYCHOLOGICAL SERVICES, P.C.

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RELEASE OF INFORMATION
Authorization for the Disclosure of Protected Health Information

Name of Patient: _____ DOB:_____

1. I authorize my healthcare practitioner, _____ at Osika & Scarano Psychological Services, P.C., and/or administrative and clinical staff to SEND /RECEIVE my (or my child's) protected health information, as specified below, to the persons indicated below:

   Name of Person/Agency: _____

   Address: _____

   _____

2. I am hereby authorizing the disclosure of the following protected health information:
   _____

3. This protected health information is being used or disclosed for the following purposes:
   To collaborate regarding the treatment plan and diagnosis

4. This authorization shall be in force and affect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my healthcare practitioner, at Osika & Scarano Psychological Services, P.C., 5 Pine Street Glens Falls. I understand that a revocation is not effective to the extent that my healthcare practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPPA or any other federal or state law.

7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient or Parent Date

_____
Print Name of Patient or Parent