# Osika & Scarano Psychological Services, P.C.

125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801
430 Franklin Street, Schenectady, NY 12305
**phone: 518.745.0079 fax: 518.745.4291 www.OSPsychServices.com**

## Release of Information / Authorization Form

(If you decline to authorize the release of your information at this time, please continue to the following page.)

1. I authorize my healthcare practitioner, at Osika & Scarano Psychological Services, P.C., and/or administrative and clinical staff to disclose my protected health information, as specified below, to the persons indicated below who will receive the information:

2. I am hereby authorizing the disclosure of the following protected health information:
   **Diagnostic Examination and Treatment Plan**

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., 125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801. I understand that a revocation is not effective to the extent that my healthcare practitioner has relief 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 HIPAA 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.

Patient Name:

Patient/Guardian Signature:_____ Date:_____

Print Name:

**Date of Birth:**

(Provide a copy of this form to the patient.)