OSIKA & SCARANO
PSYCHOLOGICAL SERVICES, P.C.
Five Pine Street Glens Falls, NY 12801 8 Williams St. Elizabethtown, NY 12932
400 Rella Blvd. Suite #165 Suffern, NY 10901

Thomas S. Osika, Ph.D. Tacey Shannon, LMSW Angela Pietrantoni, Psy.D.
Gina Scarano-Osika, Ph.D. Cairenn Spooner, LCSW-R
Telephone (518) 745-0079 Fax (518) 745-4291 Urgent (518) 744-7978

Authorization for Disclosure of Protected Health Information

Name of Patient: _____ DOB: _____

1. I authorize the healthcare practitioner **[name]** _____ at the agency noted above (the 'Practitioner") and/or the administrative and clinical staff of the Practitioner to disclose/receive my (or my child's) protected health information, as specified below, to **[name and address of person/entity to receive information]**:

_____

_____

_____

2. This protected health information is being used or disclosed for the following purposes:

3. I specifically authorize the disclosure by the healthcare practitioner of the following types of protected health information. Placing my initials where appropriate below, I am authorizing the release for each type of protected health information:

_____Session Summary
_____Diagnostic Examination
_____Treatment Summary
_____Other

4. This authorization shall be in force and effect 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 the Practitioner at the address above. I understand that a revocation is not effective to the extent that the 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 HIPAA or any other federal or state law, provided however, that Confidential HIV Related Information and Alcohol/Substance Abuse Treatment Information may not be re-disclosed without my authorization unless permission to re-disclose such information is granted by federal or state law.

7. The 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 of Minor Patient) Date