

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

Please read this form carefully. Incorrectly completed forms will be voided.

The name of the patient:

The patient's date of birth:

The name of the patient's therapist at Osika & Scarano:

The person with whom you would like your provider to be able to communicate regarding your treatment:

Contact information for this person. Please include phone and fax numbers.

1. I authorize my healthcare practitioner, at Osika & Scarano Psychological Services, P.C., and/or administrative and clinical staff to disclose and receive my protected health information, as specified below, with the persons indicated above.
2. I hereby authorize the disclosure and receipt of the following protected health information:
Examinations, treatment plans, and progress notes.
3. This protected health information is being used, disclosed, or received for the following purposes:
To collaborate regarding diagnosis and treatment of the patient.
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 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/Guardian Signature: _____ Date: _____

Print Name: