



Psychiatric Services of  
Central New York

*Creating Balanced Living<sup>SM</sup>*

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## Authorization To Release Healthcare Information

**EMERGENCY CONTACT**  
(as listed on your patient questionnaire)

**NOT A MEDICAL PROVIDER**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I request and authorize the release of healthcare information by, PSCNY, 502 Court Street, Suite 204, Utica, NY 13502, regarding myself or for the patient for whom I am the parent or legally authorized representative.

Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Telephone: \_\_\_\_\_

**This request and authorization applies to:**

Healthcare information relating to the following treatment, condition, or dates:

\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**Yes**    **No**

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the patient(s) listed above.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_