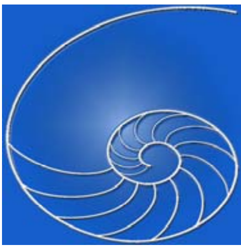

Psychiatric Services of
Central New York

*Creating Balanced Living*SM

Elizabeth Farnum, MD
Maria Allen, MS, PMHNP-BC, ANP-BC

502 Court Street, Suite 204
Utica, NY 13502

Phone: 315.792.7626
Fax: 315.792.7675

## Primary Care Physician

# AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ Social Security #: ______________

Address: ______________________________________________

Phone: ______________ E-Mail Address: ______________________

**1) I authorize PSCNY to use/disclose the above named individual's health information:**

☐ **To Release Information To** ☐ **To Obtain Information From**

Name: ______________________

Address: ______________________________________________

City: ______________ State: ______________ Zip Code: ______________

Phone: Fax: E:mail: ______________________________________________

**2) Description of information that may be disclosed ( Office Use - Patient to initial checked boxes):**

☐ Entire Medical Record
☐ History & Physical
☐ Psychiatric / Mental Health Records
☐ Summary of Hospital Records
☐ Emergency Room Record
☐ Laboratory Results
☐ Drug / Alcohol Related Records
☐ Other ______________________
☐ STD Results, HIV/AIDS testing. I understand that the entity listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

**3) The information will be used/disclosed for the following purposes( Office Use - Patient to initial checked boxes):**

☐ Continuity / Transfer of Care
☐ Legal
☐ Disability
☐ Insurance / Payment of Bills
☐ Other: ______________________________________________

**4) I understand that by authorizing Psychiatric Services of Central New York (PSCNY), to use/disclose the information, that they may receive compensation for reasonable expenses incurred for making photo copies of my records.**

**5) I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or request a copy of any information disclosed under this authorization.**

**6) Authorization expires when services are no longer being provided by PSCNY.**

______________________________________________

**Signature of Patient or Legal Representative** **Date**

______________________________________________

**If signed by Legal Representative, Relationship to Patient**