Four Winds SARATOGA
a psychiatric health system

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_____

Date of Birth _____

FOUR WINDS - SARATOGA
PSYCHIATRIC SERVICE, PC
30 CRESCENT AVENUE
SARATOGA SPRINGS, NEW YORK 12866
PHONE: (518) 584-3600 FAX: (518) 583-9301

I authorize Four Winds Psychiatric Service, PC to **obtain from or release** to any Person/Program within the Organization / Program(s) listed below:

Person/Agency:

Address:

City, State, Zip:

Phone: Fax:

Covering the period of healthcare:
From date _____ to date _____

- ☐ Diagnosis
- ☐ Dates of Service
- ☐ Initial Evaluation
- ☐ Progress Notes
- ☐ Medical: H&P, Labs, EKG, Immunizations, etc
- ☐ Nursing Notes
- ☐ Educational Materials/Verbal Academic Reports
- ☐ Medication Information
- ☐ Billing Issues & Payment Arrangements
- ☐ Other (Specify):_____
- ☐ Whole Record (a fee of $0.75/page may be applied)
- ☐ Pertinent Letters / Correspondence

This information will be used for the following purpose(s):

- ☐ Evaluation and Continuing Treatment / Coordinating Care
- ☐ Educational Placement / Other Educational Concerns
- ☐ Insurance Eligibility / Benefits / Claims Resolution
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Health Information Management. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire 90 days after the last date of treatment and may be used until such time for either a one-time release of periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district and any school within the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York State law.

Signature of Patient or Legal Guardian	**Date**
If Signed by Legal Guardian, Relationship to Patient	**Signature of Witness (over the age of 18)**

TO CANCEL PERMISSION OR REFUSE DISCLOSURE OF RECORDS FILL OUT THE INFORMATION BELOW

☐ I hereby cancel my permission to release information to the above named person or entity.	☐ I hereby refuse to authorize the release of information to the above named person or entity.
Signature of Patient or Legal Guardian	**Date**