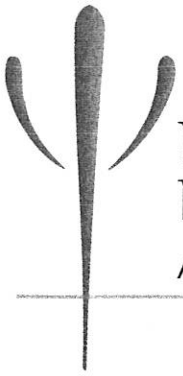

Northeast Psychological Associates

AUTHORIZATION FOR RELEASE OF/TO OBTAIN INFORMATION

NAME: _____

DATE OF BIRTH: _____

I authorize Northeast Psychological Associates to:

☐ obtain from ☐ release to

_____
Person/Agency

_____
Address

_____

_____
City/State/Zip

_____ _____
Phone Fax

Northeast Psychological Associates
435 New Karner Road
Albany, New York 12205

Phone: (518) 456-2060
Fax: (518) 456-2361
Email: info@nepsych.com

Obtain	Release		Obtain	Release	
_____	_____	Diagnosis Only	_____	_____	Progress & Plan
_____	_____	Dates of admission and/or discharge	_____	_____	Progress Notes
_____	_____	Admission/Psychiatric Assessment	_____	_____	Educational Materials/Verbal Academic
_____	_____	Discharge Summary	_____	_____	Reports
_____	_____	Verbal/Written Communication	_____	_____	Other: _____
_____	_____	Psychological Testing			(Please Specify)
_____	_____	History & Physical / Labs			
_____	_____	Other Medical Information			

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

_____ Evaluation and Continuing Treatment

_____ Coordinating Care

_____ Educational Placement/Other Educational Concerns/Billing School District for Education

_____ Other: _____
(Please Specify)

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing. 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 in one year from the date of the signature below and may be used until such time for either a one time release or 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.

I further understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFP Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Signature of Witness

I hereby cancel my permission to release information indicated on the reverse side, to the person/organization/program whose name and address is:

_____

_____

_____

_____

Signature of Patient Date Signed

I hereby refuse to authorize release information indicated on the reverse side, to the person/ organization/facility/program whose name and address is:

_____

_____

_____

_____

Signature of Patient Date Signed

RECORD OF INFORMATION RELEASED PURSANT TO THIS RELEASE

Date	**Specific Document Released**	**Staff Person Releasing the Information**