AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name________________________

Date of Birth ________________________

FOUR WINDS SARATOGA
30 CRESCENT AVENUE
SARATOGA SPRINGS, NEW YORK 12866
PHONE: (518) 584-3600 FAX: (518) 580-1514

I authorize Four Winds Saratoga to obtain from or release to any Person/Program within the Organization/Facility/Program(s) listed below

Person/Agency:

Address:

City, State, Zip:

Phone: Fax:

Covering the period of healthcare: ☐last 1 yr or ☐last 2 yrs or
From date _______________ **to date** _________________

Obtain	Release	
☐	☐	Diagnosis Only
☐	☐	Dates of Admission and Discharge
☐	☐	Integrated Assessments/Suicide Risk and Substance Abuse Assessments
☐	☐	Clinical Discharge Summary
☐	☐	Verbal/Written Communication for Discharge
☐	☐	Medical: H&P, Labs, EKG, Immunizations, etc.
☐	☐	Progress Notes

Obtain	Release	
☐	☐	School Discharge Summary/Educational Materials/Verbal Academic Reports
☐	☐	Medication Information only
☐	☐	Billing Issues & Payment Arrangements
☐	☐	Applications
☐	☐	Psychological Testing
☐	☐	Other(Specify):_________________________
	☐	Whole Record (a fee of $0.75/page may be applied)

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
☐ Insurance Eligibility/Benefits/Claims Resolution
☐ Legal ☐ 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 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.

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**