Penfield Psychiatry
421 Penbrooke Dr. Suite 12A
Penfield, NY 14526
(585) 388-6000

Authorization to Release/Obtain Healthcare Information

Patient Name: _____ DOB:_____ SS#:_____

I request and authorize **Penfield Psychiatry**, to Release/Obtain healthcare information of the patient named above To/From:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

This request and authorization applies to:

____ Healthcare information related to the following treatment, condition, or dates:

_____

____ All healthcare information

____ Other: _____

THIS INFORMATION MAY BE RELEASED BY

( ) Written ( ) Fax ( ) Verbal Exchange ( ) E-mail ( ) Mail

I hereby declare that I am the ( ) Patient ( ) Parent/Legal Guardian

This authorization will expire in 12 months from the date of the signature below.

_____ _____
Signature of patient or representative Date

HIPPA *guidelines limit the amount of protected health information that can be released. Only clinically relevant information will be released. I understand that I may revoke this release at any time. I understand that I must give written notification to revoke this release.*