MILESTONE PSYCHIATRIC & PSYCHOLOGICAL SERVICES, P.C.
1151 Pittsford Victor Rd Ste. 103 Pittsford, NY 14534 (p) 585-593-9815 (f) 716-372-9497
3460 Riverside Dr ▪ Wellsville NY 14895 (p) 585- 593-1859 (f) 585-593-5463
15 Pleasant St. Hornell, NY 14843 (p) 607-324-9240 (f) 607-324-9744

Authorization for Release of Confidential Information

Patient Name:_____ Date of Birth _____/_____/_____

Authorize _____ at Milestone PPS, PC: 15 Pleasant St. Hornell, NY 14843

☐ release information to: ☐ obtain information from: ☐ exchange information with:

Person/organization receiving/communicating the information:

Name: _____

Address: _____

Phone: _____Fax: _____

Description of Information to be received/disclosed (check all that apply):

☐Psychological/social assessment
☐Psychiatric evaluation
☐Treatment plans
☐Progress notes
☐Discharge summaries
☐Subpoena or legal process
☐Worker's Compensation Claim
☐Disability Claim
☐Medical history
☐Lab/radiology reports
☐Juvenile/justice records
☐Social services records
☐Verbal communication
☐Written communication
☐Other _____

The dates records to be disclosed _____/_____/_____ TO ____/_____/_____ ☐ ALL

Purpose of release: ☐ evaluation ☐ continuity of care ☐ medication history ☐ other _____

One Time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the destination identified herein. **My authorization will expire**:
☐ When acted upon
☐ 90 days from this date
☐ Other: _____

Periodic Use/ Disclosure: I authorize the periodic use or disclosure of the information described above to the destination identified herein. **My authorization will expire**:
☐ When I am no longer receiving services from above identified person/ organization/ facility/ program
☐ One year from the date signed
☐ Other: _____

I understand that this authorization is voluntary. **Prohibited Disclosure:** I understand that my health information may be protected by the Federal Regulations for Privacy of Individually Identifiable Health Information (Title 45 if the Code of Federal Regulations, Parts 160, and 164) For Alcohol and Drug Abuse this information is protected by federal l confidentiality rules (42 CFR, Part 2). The federal rules prohibit making any consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this consent at any time except that action has been taken in reliance on it (e.g. probation, parole, etc) and that in any event this consent expires automatically as described above. I also understand that I may inspect and upon payment of the usual fee, receive a copy of the released information and I may receive a copy of this consent form. (A copy or facsimile of this authorization shall be as valid as the original).

PROHIBITION ON CONFIDENTIALITY: I understand mental/physical health professionals and teachers must report child sexual/physical abuse and neglect, threats of suicide and threats of bodily harm to others.

_____ _____
Signature Date Parent/Guardian Date

_____ _____
Witness Date Relationship to patient