New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC
125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801
phone: 518.744.7302 fax: 518.909.6423 www.newhopepsychnpservices.com

Release of Information / Authorization Form

Please read this form carefully. Incorrectly completed forms will be voided.

The name of the patient:

The patient's date of birth:

The name of the patient's nurse practitioner at New Hope:

The person with whom you would like your provider to be able to communicate regarding your treatment:

Contact information for this person. Please include phone and fax numbers.

1. I authorize my healthcare practitioner, at New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC, and/or administrative and clinical staff to exchange my protected health information, as specified below, with the persons and organizations indicated above.
2. I am hereby authorizing the disclosure of the following protected health information:
   Examinations, treatment plans, and progress notes.
3. This protected health information is being used or disclosed for the following purposes:
   To collaborate regarding diagnosis and treatment of the patient.
4. This authorization shall be in force and affect until one (1) year after the date below, at which time this authorization to disclose protected health information shall expire.
5. I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to my healthcare practitioner at: New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC, 125 Broad Street, One Broad Street Plaza, Glens Falls NY 12801. I understand that a revocation is not effective to the extent that my healthcare practitioner has relief on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.
6. I understand that information disclosed pursuant to this authorization may be disclosed by the parties indicated above, and may no longer be protected by HIPAA or any other federal or state law.
7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure, except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient/Guardian Signature:_____ Date:_____

Print Name: