Authorization for Release of Information

Patient name			
Address			
City, State, Zip			-
DOB:	/ /		
Phone	( ) - X		

Fill out the information of the physician, psychiatrist, therapist, health care provider, or other person whom you are requesting information from, or who I will be releasing information to:

To/From			
Address			
City, State, Zip			-
Phone	( ) - X		

☐ I hereby authorize and give my consent to Elizabeth V. Getter, MD to discuss the following confidential and private health information:

- ☐ Psychiatric history, diagnoses and treatment;
- ☐ Substance Use history, diagnoses and treatment
- ☐ Medical history, diagnoses and treatment

with the above named provider, in his/her role as my:

☐ health care provider ☐ psychotherapist ☐ prior psychiatrist ☐substance abuse treatment provider ☐case-manager ☐ *other* _____

in order to facilitate the coordination of my health care.

This release also allows the above named provider to discuss my pertinent personal health information with Dr. Getter.

☐ I request that a copy of my ☐medical records ☐psychiatric records ☐CXR ☐EKG ☐ laboratory results ☐_____

be sent to my psychiatrist, ☐Elizabeth Getter ☐ other_____

I understand that I am not required to give this consent and that if I refuse I will be offered psychiatric services but the potential effect upon the provision of my mental health care will be discussed with me.

This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken; it shall be effective only long enough to answer the purpose for which it is given, and no further confidential information will be released without the execution of an additional written statement of my consent.

This document authorizes the above named parties to release the information listed for the purposes described. The recipients of the confidential information are legally obligated under Title 42, Part 2 of the Code of Federal Regulations (Substance Abuse) and under NYS-MHL Section 33.13 (Mental Health) to maintain the information confidential, are restricted from re-disclosure without further written consent from you unless otherwise permitted under law.

Date of Consent: _____ Signature: _____

Date of Expiration of Consent: _____ Witness: _____

Office (212) 677-0075 Fax (212) 807-0706