

**New Horizons of the Genesee Valley, Inc (NHGV)**

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL, EDUCATIONAL, and CLINICAL INFORMATION**

RE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I am the person legally responsible for the above named individual and I authorize NHGV to:

 the patient and I authorize NHGV to:

OBTAIN INFORMATION FROM RELEASE INFORMATION TO

2. Primary Care Physician Facility/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Psychiatrist Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Agency City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 School Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other Health Care Provider

 Other – Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Specific information to be released or obtained

 All **clinical evaluation/plans** necessary for clinical treatment and services (e.g. psychiatric, psychological, social evaluations, comprehensive treatment plan(s) and/or review(s), special therapies)

 All **school/educational information** necessary for planning (e.g. report cards, IEP information, educational testing, CSE minutes)

 **Discharge Summary**

 **Other** (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is required for the purpose of any necessary and ongoing medical, clinical, and educational needs inclusive of evaluations and recommendations for further treatment.

By signing below I am stating that:

* I understand the information disclosed, as permitted by this authorization, may be re-disclosed by NHGV, and may no longer be protected by NHGV after re-disclosure. I do understand that local, state, and federal laws do exist to protect the confidentiality of this information.
* I understand that I have the right to revoke and/or restrict this authorization at any time, provided I submit a request in writing to NHGV by executing the revocation form. Any revocation shall not apply to the extent that NHGV has already taken action in reliance on this authorization.
* I authorize the periodic, on-going disclosure of the above information (please check one).

This authorization is valid from \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ (if expiration date exceeds discharge of services, authorization will expire at discharge from that time. If authorization is granted after discharge from services, the authorization will automatically expire 90 days after signing.

This authorization is valid from \_\_\_\_\_\_\_\_\_\_\_\_ and expires when discharge from services occurs.

\_\_\_\_\_\_\_\_\_\_ (please initial) I have been offered a copy of this signed authorization form.

FOR THE PURPOSES OF INFORMED CONSENT, ALL BLANK AREAS **MUST** BE COMPLETED BEFORE THE PATIENT OR LEGAL GUARDIAN SIGNS THE AUTHORIZATION.

Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE SEND ALL INFORMATION REQUESTED TO:

**Dr. Mark Spezzano**

**3 Episcopal Avenue**

**Honeoye Falls, New York 14472**