**c/o Haven Oaks Farm**
**46 Reynolds Rd.**
**Fort Edward, NY 12828**
**Phone: (518) 573-0329**
**Fax: (518) 747-2194**

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (print): _____

**I hereby authorize the use or disclosure of my individual, identifiable protected health information as described below.** I understand that this authorization is voluntary. I understand that I have the right to revoke this authorization at any time. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization. I understand that if the organization authorized to receive the information is not a health plan, health care provider, or a clearing house, the release of information may no longer be protected by Federal (HIPAA) privacy regulations, except that a recipient may be prohibited from re-disclosing chemical abuse/dependency and mental health information under the State (Mental Hygiene Law) confidentiality requirements. **I hereby authorize Shannon Myles, LCSWR, to release/receive my health information to/from:**

Person/Organization: _____

Address:_____

Phone Number/Fax Number:_____

**Information to be released and obtained:**

- __ Entire Medical Record
- __ Mental Health Evaluation/Treatment Information
- __ Substance Abuse Evaluation/Treatment Information
- __ Education Information
- __ Other

_____

Signature of Patient Date

_____

Signature of Guardian/Authorized Person Date

_____

Signature of Witness Date