NYC Neuropsychiatry

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize NYC Neuropsychiatry to:

□ Release information to:

□ Obtain information from:

□ Exchange information with:

Name: _____

Contact information: _____

The information requested or authorized for release or exchange pertains to:

□ All information regarding assessment, diagnosis and treatment

□ Mental Health

□ HIV/AIDS

□ Drug or Alcohol Abuse

This authorization is valid until date _____.

I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my treatment. I understand that there may be a fee associated with the copying of my records.

Signature: _____

Printed Name: _____ **Date: _____**