Iadeluca NP Psychiatry
7 Corporate Drive
Clifton Park, New York, US - 12065

Iadeluca NP Psychiatry ROI

IADELUCA NP PSYCHIATRY PLLC
Clifton Park, NY 12065

Office Phone number: 518-520-1817
Office fax number: 518-240-4485

Authorization for Release of Health Information

At Iadeluca NP Psychiatry, we would like to have the ability to collaborate with your primary care physician, therapists, past providers, and other members of your treatment team to improve the quality of your care as desired. If you do not have all the information requested, please fill in as much as you know

I authorize Iadeluca NP Psychiatry to send, receive, or discuss information from my health record which may include diagnostic and treatment information with the following individuals or systems:

Therapist Name or Organization:

Address:

Phone:

Fax:

Primary Care Practitioner:

Address:

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Phone:

Fax:

Pharmacy preferred: *

Address: *

Phone number:

School - used for school counselor or teachers for information including inattention, hyperactivity in the school setting (if specific school counselor please include their name):

Address:

Phone Number:

Fax:

Any other practitioners you would like to involve in your care:

Address:

Phone:

Fax:

1. I understand that this authorization will expire 90 day after discharge

2. I understand that I may revoke this authorization at any time by notifying Iadeluca NP Psychiatry PLLC in writing

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

5. My health care and payment for my health care at Iadeluca NP Psychiatry will not be affected if I do not sign this form.

6. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

PATIENT (or guardian) SIGNATURE ______________________________