Print Form

# Rita M. Oliverio, Ph.D.

## Authorization to Release Psychological Record Information

Patient's Name: Date Of Birth:

Address:

City: State: Zip Code:

Patient's Daytime Phone: Evening Phone:

Date Of Request: Date Required:

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☐ **I authorize Rita M. Oliverio, Ph.D. to release information to:**

Name of Provider/Facility:

Address:

City: State: Zip Code:

Provider/Facility Phone Number:

☐ **I authorize Rita M. Oliverio, Ph.D. to obtain information from:**

Name of Provider/Facility:

Address:

City: State: Zip Code:

Provider/Facility Phone Number:

Purpose for this request:

☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other ☐ Transfer Of Care

Specify Type of Record Requested:

Authorization valid for:

☐ This request only ☐ One year from the date of this authorization only

*I understand that:*

- *My right to healthcare treatment is not conditioned on this authorization.*
- *I* may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care of medical insurance provider covered by privacy regulations, the information stated above could not be redisclosed.
- Released of HIV-related information requires additional authorization.
- There may be a charge for the requested records up $.75 cents per page.

**NOTE: Records are faxed in cases of medical necessity only.**

_____ _____

Print / Signature of Patient/Representative Date

Relationship to Patient (if requester is not patient): _____

96 Appletree Lane, Clifton Park, NY 12065

518-373-2208