LEAH FROMM, NPP
PSYCHIATRIC SERVICES

21 Willow Pond Way, #201, Penfield, NY 14526
P: (585) 454-9662
F: (585) 735-4646
LeahFrommNPP.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ **Date of Birth:** ______________

Select all of the following types of Authorization that apply.
☐ Medical Information ☐ Mental Health Information ☐ Alcohol/Drug Treatment

This Authorization allows Leah Fromm, NPP to ☐ **Release** information to **AND/OR** ☐ **Receive** information from

Name of Person or Organization: ______________________
Address: ______________________
Telephone: ______________ **Fax:** ______________

Purpose of this request:
☐ Treatment ☐ Legal ☐ Insurance Coverage ☐ Personal ☐ Other: ______________

This information may be released by:
☐ Copy ☐ Fax ☐ Electronic Means ☐ Verbal Means ☐ Other: ______________

I authorize the release of the following health information and/or medical records, if such information exists:
☐ All information pertaining to medical and psychiatric evaluation and treatment, including drug and alcohol use information, and excluding psychotherapy notes
☐ Psychotherapy Notes **ONLY** (IMPORTANT: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected information)
☐ Other: ______________________

Use/Disclosure Frequency: (check ONE)
☐ **One Time Use/Disclosure**: I hereby permit the one-time use or disclosure of the information described above.
☐ **Periodic Use/Disclosure**: I hereby permit the periodic use or disclosure of the information described above, as often as necessary to fulfill the purpose identified above.

This authorization will expire: ☐ 90 days after termination of care ☐ Other: ______________

I understand that my right to healthcare/treatment is not conditioned on this authorization. I may revoke this authorization at any time by submitting a written request to Leah Fromm. I understand that the cancellation will not apply to information already released in response to this authorization. If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations, I understand the information indicated above could be re-disclosed. Psychiatric and alcohol/drug treatment information is protected under Federal and State Regulations governing confidentiality of protected health information and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. Further disclosure is prohibited by law. The release of HIV-related information requires additional authorization. There may be a charge for the requested records.

Patient Signature: ______________________ **Date:** ______________
Legal Representative Signature: ______________________ **Date:** ______________
Legal Representative Name: ______________________
Relationship to Patient: ______________________