UPSTATE PSYCHIATRIC CONSULTING LLC
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AUTHORIZATION FOR RELEASE OF INFORMATION

Pursuant to HIPAA (45 CFR §164.508) and, where applicable, 42 CFR Part 2 (Substance Use Disorder Records).

1. PATIENT INFORMATION

Patient Name

Date of Birth

Address

Phone

Email

2. PERSON AUTHORIZING THIS RELEASE

- ☐ Self (patient)
- ☐ Healthcare Power of Attorney
- ☐ Legal Guardian
- ☐ Parent (for minor patient)
- ☐ Other:

If you are a legal guardian, healthcare POA, or court-appointed representative, please attach documentation of authority.

Representative Name (if not patient)

Representative Phone

3. DIRECTION OF RELEASE

I authorize Upstate Psychiatric Consulting LLC to:

- ☐ Send information TO the person/organization listed below
- ☐ Receive information FROM the person/organization listed below
- ☐ Both send and receive

Recipient / Source Name

Organization / Practice

Address

Phone

Fax

4. INFORMATION TO BE RELEASED

- ☐ Psychiatric evaluation and/or diagnostic summary
- ☐ Medication management records and prescription history
- ☐ Progress notes and treatment summary
- ☐ Medical history and evaluations
- ☐ Mental health evaluations
- ☐ Laboratory results
- ☐ Developmental and/or social history
- ☐ Discharge or closing summary
- ☐ Other: _____

Time period: From _____ To _____ (or) ☐ All records on file

5. SUBSTANCE USE DISORDER RECORDS — ADDITIONAL AUTHORIZATION

This section applies ONLY if records include substance use disorder (SUD) information protected under 42 CFR Part 2. SUD records carry additional federal protections. The recipient may NOT re-disclose these records without a separate authorization.

☐ I specifically authorize release of substance use disorder records, understanding the additional protections under 42 CFR Part 2.

6. PURPOSE OF RELEASE

- ☐ Coordination of care / treatment planning
- ☐ Continuing or updating treatment
- ☐ Referral to another provider
- ☐ Determining eligibility for benefits or program
- ☐ Other: _____

7. EXPIRATION

- ☐ One year from the date of my signature: _____
- ☐ Specific date: _____
- ☐ Specific event: _____

If no expiration is selected, this authorization expires one year from the date of signature.

8. YOUR RIGHTS

- This authorization is voluntary. You may refuse to sign without affecting your treatment or insurance benefits.
- You may revoke this authorization at any time by submitting written notice to this office. Revocation does not apply to information already released.
- You have the right to receive a copy of this signed authorization.
- Records fees: A reasonable, cost-based fee may be charged for copying and transmitting records as permitted by HIPAA.

9. SIGNATURE

Patient / Representative Signature

Date

Printed Name

Witness signature (required if patient is unable to sign):

Witness Signature

Witness Date

Witness Printed Name