75 Seminary Hill Road
Carmel, NY 10512

Fax: (845) 704 - 6173
Phone: (845) 225 - 3400

MR Number_____ Patient Name:_____

AUTHORIZATION TO RELEASE INFORMATION FROM THE PATIENT RECORD

PATIENT NAME	DATE OF ADMISSION	BIRTHDATE	SOCIAL SECURITY NUMBER

I do hereby consent and authorize Arms Acres, Inc. to obtain from and release to:

NAME OF ORGANIZATION	NAME OF PERSON AND/ OR POSITION
STREET ADDRESS, INCLULDING APARTMENT OR SUITE NO. IF APPLICABLE	
CITY, STATE AND ZIP CODE	

PHONE NUMBER, INCLUDING AREA CODE	FAX NUMBER INCLUDING AREA CODE	E-MAIL ADDRESS

I authorize Arms Acres clinical, medical, administrative, and clerical personnel to release information about me as follows:
The following information pertaining to this admission:

- ☐ Presence in treatment (admit/ discharge dates)
- ☐ Medical history and physical examination
- ☐ Results of diagnostic tests and testing
- ☐ Psychiatric/ Psychological consults
- ☐ Psychosocial/ Diagnostic Summary
- ☐ Diagnosis/ Prognosis
- ☐ Treatment plan
- ☐ History and behavior related to diagnosis
- ☐ Educational discharge summary
- ☐ Description of progress in treatment
- ☐ Discharge summary
- ☐ Continuing care plan
- ☐ Educational records, achievements, assessments
- ☐ Immunization records
- ☐ Legal history
- ☐ other: _____

This information is needed for the following purpose(s):

- ☐ To provide ongoing treatment/ continuing care
- ☐ To provide educational services
- ☐ Obtain insurance, employment, government benefits
- ☐ Coordinate services with authorized school officials
- ☐ To coordinate treatment efforts with my family/ concerned person
- ☐ To coordinate treatment and continuing care efforts with my employer
- ☐ To coordinate educational planning and re-entry program with school persons
- ☐ To enable judges, attorneys, probation/ parole officers to support treatment goals & make legal decisions on my behalf
- ☐ Other: _____

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purpose(s) specified above. The duration of this authorization is for this admission, and no longer than 120 days unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this authorization at any time by notifying Arms Acres Department of Health Information Management in writing, except to the extent that action has been taken in reliance on my authorization. I understand that I will be expected to pay .75 per page for copies of records sent for purposes other than to provide for continuing care.

Specify date, event, or condition upon which authorization expires sooner than 120 days from signing	
Patient Signature	Date
Parent or Legal Guardian Signature	Date
Legal Representative Signature	Date
Witness Signature	Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Additionally, these records are protected by 45 CFR Parts 160 and 164 (HIPAA).