CNY TMS Psychiatry
1/2 Orange St., Ste 2
Marcellus, NY 13108

Direct: (315) 671-2140
Fax: (315) 673-2434

Date of Request: _____

CLIENT CONSENT TO RELEASE INFORMATION

Client Name:_____ Date of Birth: _____

Other Alias:_____ SSN:_____/_____/_____

I hereby authorize **the below health care or pharmacy providers** to use or disclose, in verbal and/or written form, the specific information requested below, to CNY TMS Psychiatry and its affiliate management services provider, CNY TMS Psychiatry for the purpose of receiving TMS therapy and to obtain prior-authorization for TMS treatment services.

Psychiatrist _____ Tele:_____ Fax:_____
Therapist _____ Tele:_____ Fax:_____
Other Doctor _____ Tele:_____ Fax:_____
Pharmacy _____ Tele:_____ Fax:_____
Hospital _____ Tele:_____ Fax:_____
Other _____ Tele. _____ Fax: _____

One-Way Release: _____ Two-Way Release: _____

Check only the specific information to be used or disclosed:

_____Treatment Summary
_____Psychological Testing
_____Psychological Evaluation
_____Psychiatric History
_____Substance Use/Abuse History
_____School Functioning/Educational
_____School Testing/Evaluations
_____Medical Information History
_____Current / Previous Medications
_____Hospital Admit Summary
_____Hospital Discharge Summary
_____Other: _____
_____

The information is being requested for the following purpose(s):
Transcranial Magnetic Stimulation (TMS therapy)

This authorization shall remain in effect for 90-days from the date of the request.

Continued on the reverse →

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This authorization shall remain in effect 90-days from the date signed below.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I understand that I may revoke this authorization any time before the expiration date (except to the extent that actions have been taken in reliance on it) by submitting a written revocation letter to CNY TMS Psychiatry
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization
- I hereby release CNY TMS Psychiatry from any and all legal responsibility or liability or for any consequences of either: 1) having non- stipulated information maintained in confidence or privacy; or 2) disclosing stipulated information.

Patient Signature:_____ Date: _____
(Age 18 and over)

Parent/Guardian Signature:_____Date: _____

Witness Name:_____Date: _____
The witness can attest to the identity of the person(s) signing above, per secure, written, identifying information.

NOTICE TO RECEIVING AGENCY: The patient's record is privileged information, which is protected by various State and Federal laws. Such information may not be disclosed to other persons or entities, including those within the organization wherein the patient is employed, without a separate written authorization from the patient.

Please fax to:
CNY TMS Psychiatry
Jason Stepkovitch, MD
Fax: 315-673-2434