



**RELEASE OF INFORMATION FROM**  
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_  
(Patient Name) (Address) (Date of Birth)

do hereby authorize \_\_\_\_\_ to release information  
(Clinician Name)

contained in my medical records (except psychotherapy notes) created by the provider named above to the individual(s) or organization(s) listed below for the purposes of assessment, treatment, information management, and payment services related to participation in the Problem Gambling Resource Center.

1. Name & Address of the person(s) or organization(s) to whom disclosure is to be made:

\_\_\_\_\_  
New York Council on Problem Gambling

\_\_\_\_\_  
New York State Office of Addiction Services and Supports

\_\_\_\_\_  
The recipient is prohibited from re-disclosing these records without my authorization unless permitted to do so under State or Federal Law.

This **Authorization for the Release of Confidential Information** shall become effective on the date of execution of my signature hereinafter, and this **Authorization**, which grants specific authority for the release of protected health information by Clinician Name, shall remain valid until 60-days post discharge of care with Clinician Name, upon which this **Authorization** shall automatically expire. I retain the right to revoke this **Authorization** at any time by providing a written notice to Clinician Name, but I understand and agree that my consent to release information shall remain in effect until the date the revocation is date stamped in by the Medical Records Department, and any documents released previous to that date are considered to be authorized and approved by me. I also understand that any disclosure/release must comply with New York State Law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that re-disclosure of this information to a party other than the one(s) designated above is forbidden without additional written authorization on my part.

\_\_\_\_\_  
Signature of Client or Participant

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Printed Name of Client or Participant

\_\_\_\_\_  
Printed Name of Representative

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.