

 Authorization for Release of

 Protected Health Information

**Please complete all sections and sign as indicated. This authorization will expire one year from signed date or on:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Patient Name:** | **Date of Birth:** |
| Address: |
| Phone: |
| **Release information from:** | **Release information to:** |
| ☐ The Via Center, PC3055 Washington Road, Suite 101McMurray, PA 15317 Phone/Fax: (724) 260-0550 | ☐ The Via Center, PC3055 Washington Road, Suite 101McMurray, PA 15317 Phone/Fax: (724) 260-0550 |
| ☐ Other (Specify facility/individual, address, phone/fax/email): | ☐ Other (Specify facility/individual, address, phone/fax/email): |
| **Information to be Released (check all that apply):** Optional: From (date): \_\_\_\_\_\_\_\_\_\_\_\_ To (date): \_\_\_\_\_\_\_\_\_\_\_\_ |
| **I authorize release of the following information in the records indicated below (check all that apply):****☐ MENTAL HEALTH ☐ DRUG AND ALCOHOL ☐ HIV-RELATED** |  | ☐ Progress Notes |
| ☐ Billing | ☐ IEP/School Evaluations  | ☐ Progress Notes |
| ☐ Consultations | ☐ Laboratory/Test Results | ☐ Treatment Plan |
| ☐ Discharge Summary | ☐ Medication Management Notes | ☐ Other: |
| ☐ Initial Evaluation | ☐ Neuropsychological Testing |  |

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| --- |
| **Reason for Request:**  |
| ☐ Continuity of care | ☐ Insurance | ☐ I do not wish to disclose reasons |
| ☐ Disability Determination | ☐ Legal | ☐ Other: |
| ☐ Employer | ☐ Study/Research |  |

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics unless I indicate otherwise above. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. My decision to revoke authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. I understand that recipients may re-disclose information, which I have authorized them to receive, and that such information may no longer be protected under the Privacy Rule (HIPAA) and that The Via Center has no responsibility or liability on such a re-disclosure.

**ATTENTION: Please read this legal document carefully. By signing, you agree that you understand and accept the terms of this form.**

* If the patient is *14 years of age or older*, the patient must sign and date below.
* If the patient is *14 years of age or older and is incapable of signing*, a legally authorized representative may sign and date the form. Please indicate your legal authority (including documentation): ☐ Legal Guardian/Conservator ☐ Power of Attorney
* If the patient is *13 years of age or younger*, the patient’s parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate relationship: ☐ Parent ☐ Legal Guardian

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Signature of Patient (14 years of age or older must authorize) Date            Signature of Parent, Legal Guardian or Authorized Representative         Date

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Signature of Witness                                                                          Date                               Revised 7/2/18