

PRESTERA CENTER FOR MENTAL HEALTH SERVICES, INC.
3375 US ROUTE 60, EAST
PO BOX 8069
HUNTINGTON, WEST VIRGINIA 25705
(304) 525-7851 OR (800) 642-3434

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ is authorized to release information to:
(Who is releasing records?)

NAME AND ADDRESS: _____

(Who is receiving records?) _____

PHONE #: _____

About treatment rendered to: _____

(Consumer's name and address) _____

PHONE#: (optional) _____

Social Security Number

Treatment Dates
(approximate month/year-month/year)

Date of Birth

Requires the initials of the client or legal guardian/committee before information will be released.

Psychiatric/Psychological Information **Drug/Alcohol Information** **AIDS/HIV Information**

Reports to be released: (please check below what records are needed)

Initial Assessment (Intake) Psychosocial History Treatment Plan Medication Information
 Psychiatric Evaluation Psychiatric Re-Evaluation Psychological Report Laboratory Results
 Discharge/Transfer Summary Medical Service Notes Mental Status Statement/DFA-RT-15a
 Individual Therapy Notes Narrative Summary Other _____

Form of information to be released: Written Verbal

Records will be **FAXED ONLY IN** the event of **MEDICAL/PSYCHIATRIC EMERGENCIES**

Purpose of information to be

Released: _____

(Distinct purpose must be given, "to facilitate treatment" is not satisfactory)

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enroll in a health plan. I understand that this authorization will expire 180 days (6 months) unless an earlier date or condition/event is specified here _____. However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Prestera Center has already taken action in reliance on my authorization. (See back of authorization form).

Client Signature

Date

Witness Signature

Date

Signature of Parent/Legal Guardian/Legal Representative

Date

Note: If this authorization has been signed by a legal representative on behalf of an individual, his/her authority to act on behalf of the individual must be described here: _____

SEND RELEASE FOR MEDICAL RECORDS TO THE MEDICAL RECORDS DEPARTMENT

DATE OF INFORMATION/RECORDS RELEASED (i.e. intake 1/97) _____

SIGNATURE OF PERSON RELEASING INFORMATION: _____

DATE OF INFORMATION/MEDICAL RECORDS RELEASED: _____

TO RELEASE ELECTRONIC/WRITTEN INFORMATION, GO THROUGH THE MEDICAL RECORDS DEPARTMENT.

FEDERAL REGULATIONS (42 CFR, Part 2): The federal regulations prohibits the recipient of the information from making any further disclosures of the information, unless further disclosure is expressly permitted by the individuals' written authorization or as otherwise permitted by state and federal regulations.

SIGNATORY REVOCATION

____ I hereby **REVOKE** my permission to release information from my medical record to the Person or Organization noted on this form.

____ I hereby **REVOKE** my authorization for the request for information from the Person or Organization noted on this form.

SIGNATURE OF PATIENT/CLIENT/PERSON

DATE

RELATIONSHIP IF OTHER THAN PATIENT/CLIENT

DATE

SIGNATURE OF WITNESS

DATE

TITLE