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*** ***Date of Birth***
(approximate month/year-month/year)

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

(CONTINUED ON REVERSE)

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