PRESTERA CENTER FOR MENTAL HEALTH SERVICES, INC.

(Revised 04/2017)

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Huntington, WV 25705
Phone: 304-525-7851
Fax: 304-529-0163

511 MORRIS ST
Charleston, WV 25301
Phone: 304-341-0511
Fax: 304-345-8163

Prestera Center is authorized to ☐Release/to ☐Receive/from ☐Exchange/with information

____
(name and address)

about: ____ Maiden Name or Alias: ________________
(Client Name)

Date of Birth: ____________ SS #: _____________________ Treatment Dates: _________________
(year to year)

Information to be released may contain the following: psychiatric/psychological, Drug/alcohol, and Aids/HIV information unless noted otherwise here: _______________________________________

Information to be released: (Please check below or circle what is to be released)

_____ Administrative information (appointments, correspondence letters)

_____ Doctor information (psychiatric evaluations, medical service notes, medication info., labs, diagnosis)

_____ Clinician information (psychosocial summary, treatment plan, therapist summary, discharge summary)

_____ Substance Use Information (doctor visits, summaries, urine drug screens, discharge summary)

_____ Other: ____

Release includes verbal, written, and electronic information unless noted here: ____________________

Purpose of information to be released: ____

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 in 1 year from the date it is signed unless an earlier date or condition 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. Federal Regulations (42 CFR, Part 2): The federal regulations prohibit 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.

____ ____________________________________

Client Signature Date Witness signature Date

*****(Children 12 years and older must sign)******

____ _____________________________________

Parent/Legal Guardian/Legal Representative Date Relationship to client

Please note, if you have custody or guardianship, we will need a copy of the legal documentation

*If the authorization has been signed by a legal representative on behalf of the individual, his/her authority to act on behalf of the individual must be described here: ____.