SUNPOINTE HEALTH

320 Rolling Ridge Drive, Suite 100
State College, PA 16801
www.forabrighterfuture.com

Phone: (814) 272-2883
Fax: (814) 272-2884

AUTHORIZATION FOR RELEASE OF RECORDS / INFORMATION

I voluntarily authorize _____ of SunPointe Health to **RELEASE** records/information concerning my treatment that may contain information for mental health, HIV/Aids, sexually transmitted disease, and drug & alcohol abuse. Check if you do **NOT** want the following released: ☐Mental Health ☐HIV/AIDS ☐Sexually Transmitted Disease ☐Drug & Alcohol Abuse/Dependence

To: Name: _____

Address: _____

Phone: _____ Fax: _____

The specific and relevant type of information I wish to be **released** is:

	Special Instructions:		Special Instructions:
☐ Progress Notes	_____	☐ Psychological Evaluation	_____
☐ Email Communication	_____	☐ Psychiatric Evaluation	_____
☐ Lab & Diagnostic	_____	☐ Letter of Diagnosis & Recommendations	_____
☐ Verbal Communication	_____	☐ Other:_____	_____

Information released should cover the treatment period of ☐ start of treatment _____ to _____ **or** ☐ end of treatment
For the purpose of: ☐Continuation of Care, ☐Coordination of Care, ☐Other: _____

I voluntarily authorize _____ of SunPointe Health to **OBTAIN** records/information concerning my treatment that may contain information for mental health, HIV/Aids, sexually transmitted disease, and drug & alcohol abuse. Check if you do **NOT** want the following released: ☐Mental Health ☐HIV/AIDS ☐Sexually Transmitted Disease ☐Drug & Alcohol Abuse/Dependence

From: Name: _____

Address: _____

Phone: _____ Fax: _____

The specific and relevant type of information I wish to be **obtained** is:

	Special Instructions:		Special Instructions:
☐ Progress Notes	_____	☐ Psychological Evaluation	_____
☐ Email Communication	_____	☐ Psychiatric Evaluation	_____
☐ Lab & Diagnostic	_____	☐ Letter of Diagnosis & Recommendations	_____
☐ Verbal Communication	_____	☐ Other:_____	_____

Information released should cover the treatment period of ☐ start of treatment _____ to _____ or ☐ end of treatment
For the purpose of: ☐Continuation of Care, ☐Coordination of Care, ☐Other: _____

This authorization shall be in effect from _____ to _____ or ☐ one year from today.

I have been informed of my rights, subject to the PA Mental Health Procedures Act, the PA Drug & Alcohol Abuse Control Act, and the Health Insurance Portability and Accountability Act (HIPAA), to inspect the materials to be released. I understand these rights are limited regarding psychotherapy notes, under HIPAA. I have been informed about my right to revoke this authorization at any time by writing to "Privacy Officer" at the above address, without causing treatment to be withheld. I understand that the revocation will not apply to information already disclosed. All information released will be handled confidentially, in compliance with the Federal Privacy Act, the HIPAA, and the Pennsylvania Mental Health Procedure Act. The clinicians and employees of SunPointe Health are not responsible for how information is used and disclosed by parties to whom information is released. SunPointe Health will give me a copy of this form if I request.

_____	_____	_____	_____
Patient Name (please print)	DOB	Social Security #	Witness Signature
_____	_____		_____
Patient Signature	Patient Phone #		Witness Signature (verbal consent)
_____	_____		_____
Parent/Guardian Signature	Printed Name of Parent/Guardian		Date

NOTE: TO ANY PARTY RECEIVING CONFIDENTIAL INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. The Federal Rules and Pennsylvania State Regulations prohibit you from making any further disclosure of this information without the prior written consent of the person in respect to whom it pertains.