PRESSLEY RIDGE
AUTHORIZATION TO OBTAIN, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby request and authorize _____ to release information from the medical,
(name of facility, agency, school or person)

psychiatric, or alcohol treatment records of _____
(client name) (date of birth)

This information is to be released to: Pressley Ridge Allegheny & Beaver Family Based
(name of person, agency, facility)

1008 Seventh Avenue-101 Beaver Falls, PA 15010
(street address, city, state, zip code)

Phone: 724-843-5320 Fax: 724-843-5401

Records are requested for the purpose of (PROVIDE A DETAILED DESCRIPTION) Continuity of Treatment

Dates of written information requested from (past or present date) _____ to _____(present or future date)

Dates of verbal communication from (present date) _____ to _____(future date)

INFORMATION TO BE RELEASED		
☐ Psychiatric Evaluation	☐ Progress Notes	☐ Academic School Records
☐ Medical History/Physical Exam	☐ Medications	☐ Most Recent Evaluation Report
☐ Social/Family History	☐ Neurological	☐ Current IEP and NOREP
☐ Discharge Summary	☐ Psychological Evaluations	☐ Attendance Records
☐ Course of Treatment	Dates: _____	☐ Teacher's Observations
☐ Treatment Recommendations	☐ Psychological Testing	☐ Complete Behavior Checklist
☐ Drug and Alcohol records	Dates: _____	☐ Two-way written Communications
☐ Lab Reports	☐ Birth Records	☐ Two-way verbal Communication
☐ Summary of Hospitalization	☐ Developmental History	☐ Other: _____
Dates: _____	☐ Mother's Prenatal Records	☐ Other: _____

HIV, Behavioral Health, and Drug & Alcohol information contained in the parts of the record(s) indicated above will be released through this consent unless otherwise indicated. DO NOT RELEASE: ___ HIV ___ Behavioral Health (Psychiatric) ___ Drug & Alcohol

I understand the following:

- that if I would like a copy of this completed authorization one will be provided to me,
- that I may revoke (withdraw) this authorization at any time by completing a written form that I can get from Pressley Ridge,
- that my decision to withdraw this authorization does not apply to any release of my health records that may have taken place before the date of my request to take back the authorization,
- that my decision to withdraw this authorization may result in Pressley Ridge refusing to provide further treatment if the information was to have been used for treatment or insurance coverage (payment),
- that I have the right to read or get a copy at my expense of the information that is shared, however, there may be some times when I will not be allowed to do this,
- that information released by the agency/person named above may be re-disclosed by the agency/person that receives the information. The information would no longer be protected by the Privacy Rule.
- that Pressley Ridge may not require that I sign this form in order to receive treatment, enrollment or eligibility for services, unless that has been explained to me, and
- that I do not need to allow the information that was requested to be released. I do not need to sign this form. I choose to do so for the purpose written above. I understand that this information will be held strictly confidential.

I have read this form, it has been explained to me, and I understand its contents. This authorization remains in effect until _____. If no date is indicated, this authorization shall expire 90 days from the date this form is signed.

Client Signature (14 years of age or older): _____ Date: _____

Signature of Parent/legal representative: _____ Printed Name: _____
Relationship to Client (parent, guardian, power of attorney, etc.): _____ Date: _____

Staff Signature: _____ Date: _____

VERBAL AUTHORIZATION – NOT APPLICABLE TO HIV RELATED INFORMATION

I witness that the client (or legal representative, when applicable) is unable to provide a signature but understood the nature of this release and freely gave his/her verbal authorization (Two witnesses are required, staff signature above and additional witness)

Additional Witness Signature : _____ Date: _____