



AUTHORIZATION FOR RELEASE OF RECORDS / INFORMATION

I voluntarily authorize Sunpointe Health to:

Release Obtain Exchange Information With

Release To / Name: _____

Obtain From: Address: _____

Phone: _____ Fax: _____

The specific and relevant type of information to be included in this release:

Any and all information or communication (excluding all Psychotherapy Evaluations or Notes):

OR Please Specify:

- Psychological or Psychiatric Evaluation
- Letter of Diagnosis & Recommendations
- Progress Notes
- Lab & Diagnostic
- Verbal Communication
- Other: _____

Information released should cover the treatment period of start of treatment to end of treatment or please specify the date range _____ to _____.

For the purpose of: Continuation of Care, Coordination of Care, Other: _____

Please be aware that your medical record may contain information related to mental health treatment, HIV/AIDS, sexually transmitted diseases, and/or drug and alcohol abuse. By checking one of the options below, you acknowledge that Sunpointe will be unable to release any records containing this information.

Check if you do **NOT** want the following released: Mental Health HIV/AIDS Sexually Transmitted Disease Drug & Alcohol Abuse/Dependence:

This authorization shall be in effect for one year from the date of signature.

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

Witness Signature

Patient Signature

Patient Phone #

Witness Signature (verbal consent)

Parent/Guardian Signature

Printed Name of Parent/Guardian

Date