TRANSFORMATIONS

7000 Stonewood Drive Suite 300 Wexford, PA 15090 - Phone: 724-242-8671 Fax: 724-242-8672

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I authorize ***Transformations*** to release/obtain general medical, as well as HIV test results, psychiatric, alcohol, drug abuse information from my health record in accordance with *Pennsylvania Law (55 PA3800.20), Federal Regulations(42CFR Part 2), and/or HIPAA (CFR 164.508)*. **"Release" may be (Check all that apply):**

( ) Copies of records ( ) Review of records ( ) Verbal exchange of information

To/From:(name/address/phone#)_____

_____

_____

Information is to be used for:_____

A general medical authorization and subpoena duces tecum without a specific authorization to release HIV test results/psychiatric/alcohol/drug abuse information must have this waiver from the client or his/her empowered representative.

The below listed information is ___ to be obtained and/or ___ to be forwarded as follows:

( ) Discharge Summary	( ) Psychiatric Evaluation	( ) History & Physical	( ) NPT Results
( ) Psychosocial	( ) Progress Notes	( ) Radiology reports	( ) Lab Results
( ) Medication History	( ) ECT Results	( ) Billing _____	( ) Other_____

I understand that I have the right to refuse to sign this authorization and that the facility named above is released from all legal liability that may arise from not releasing the information requested.

This consent is subject to revocation at any time except to the extent that the facility which is to make the disclosure has already taken action in reliance on it.
This authorization will expire one year from the date signed or on this given date: _____

I hereby release Transformations from liability which may arise as a result of the use of information disclosed by this authorization, should it be presumed that such information is later used to my detriment.

PATIENT NAME: _____ **D.O.B**: _____ **SS#:**_____

PATIENT SIGNATURE: _____ **DATE**:_____

EMPOWERED REPRESENTATIVE SIGNATURE: _____ **DATE:**_____
(If patient is unable to sign) Legal guardianship must be substantiated with legal documentation accompanying this authorization.

WITNESS SIGNATURE (REQUIRED): _____ **DATE**:_____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) strictly prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of clinical or medical information if held by another party is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient. The confidentiality of HIV antibody test results is protected by Pennsylvania Law, which prohibits any further disclosure without specific written consent of the patient or as otherwise permitted by state law.

All requests for patient health information will be maintained in the patient's medical records indefinitely or until the record is destroyed in accordance with the record retention guidelines.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL