865 Eisenhower Blvd., Johnstown, PA 15904 Phone: (814)266-8840 Fax: (814)266-4922

Pediatric Care Specialists
Behavioral Health Services

www.mybehavioralhealth.com

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

_____ _____
Name of Patient Date of Birth

I, _____, hereby authorize **Behavioral Health Services** to send and receive, to and from the following agency or person by mail, fax, and / or verbal communication.

Name: _____

Address: _____

_____

Phone: _____

INFORMATION TO BE RELEASED:

_____ MH Testing Reports / Evaluations _____ Records specific to referral

_____ MH Therapy Attendance Records _____ List of Medications

_____ MH Treatment Plan _____ Balance Communication **ONLY**

_____ MH Discharge Summary _____ Insurance Communication **ONLY**

_____ Two-Way communication _____ School excuses **ONLY**

Covering the period(s) of care from (list applicable date of treatment): _____ to:_____

This authorization will remain in effect for one year from the date of signature.

DELIVERY METHOD:

_____CD/USB _____Fax _____Email :_____

_____Verbal _____Mail

IMPORTANT: I understand that faxing is not encrypted and may be accessible to others. I also understand that it may be misdirected and easily forwarded to unintended recipients. By choosing this method, I am accepting these risks.

ACKNOWLEDGEMENT _____ **INITIAL**

I understand by signing this record release that I may be charged a fee according to federal law 45 CFR164.524(c)(4) and/or PA Dept. of Health regulation **42** Pa.C.S. §§ **6152**, 6152.1 and 6155 permitting a covered entity to charge a reasonable, cost-based fee that covers labor, supplies and postage associated with providing a copy of your PHI. If a fee applies, our office will inform you and payment is due prior to sending the records. I know I am entitled to a breakdown of cost upon request. *There is no charge for office visits up to 1 year, growth charts and immunization records or when we send records to another physician directly.* **To avoid these fees, you can get most information from our patient portal.**

_____ **INITIAL**

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand I have the right to:

1) Receive a copy of this authorization

2) Refuse to sign this authorization without impacting my treatment, payments, or operations

3) Revoke this authorization (will not apply to information that has already been released)

☐ **I revoke this authorization as of _____(date)**

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

_____
Staff Signature