Fairmount
Behavioral Health System

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Fairmount Behavioral Health System to release confidential information pertaining to my evaluation and treatment from my medical record to:

Name/Facility _____

Address _____

City/State/Zip _____

Phone (if known) _____

Information from the medical record of:

Patient Name _____

Birth Date and/or Social Security No. _____

Date(s) of Treatment _____

Information to be released:

☐ History and Physical ☐ Psychological Testing ☐ Psychiatric Assessment
☐ Discharge Summary ☐ Diagnostic Studies ☐ Psychosocial Assessment
☐ Current Status
☐ Other _____

Purpose of disclosure:

☐ Medical Care ☐ Follow-up Care ☐ Insurance
☐ Other _____

I understand that my mental health treatment records are protected by federal and state laws and regulations and that such records cannot be disclosed without my written consent unless otherwise permitted by law. I have been informed of my right, subject to 55 Pa. Code 5100.33(c) to inspect the mental health records to be released. This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder.

I consent to the release of information, if any, relating to my drug or alcohol abuse or dependency, provided that disclosure is limited to exclusively to the following individuals for the following purposes: 1) medical personnel for the purpose of diagnosis and treatment; and 2) government or other officials for the purpose of obtaining benefits due me as a result of my drug or alcohol abuse or dependency. I understand that only the following information will be released: 1) whether or not I am still in treatment; 2) my prognosis; 3) the nature of the project; 4) a description of my prognosis; and 5) a statement regarding whether I have relapsed and frequency of relapse.

This authorization is valid beginning on _____ until _____ (not to exceed 60 days). I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by oral or written request to Fairmount Behavioral Health System.

I have read this consent or have had it read to me and understand its content.

Signature of Patient 14 years of age or older	Date Signed	Signature of Staff Person Obtaining Consent	Date Signed

Signature of Parent, Guardian or Authorized Representative in lieu of Patient	Date Signed

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