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

Please indicate which Service Line and State the person who is the subject of this request attended:

Service Line: ☐ Community Based ☐ Education ☐ Outpatient ☐ Treatment Foster Care ☐ Residential ☐ Other: *(Please Specify)*

State: ○ Delaware ○ Maryland ○ Ohio ○ Pennsylvania ○ Virginia ○ West Virginia ○ Other:

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

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

This information is to be released to: _____
(name of person and facility or organization, if applicable)

_____
(street address, city, state, zip code)

Phone: _____ Fax: _____

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

_____

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 Dates: _____	☐ Attendance Records
☐ Course of Treatment	☐ Psychological Testing Dates: _____	☐ Teacher's Observations
☐ Treatment Recommendations	☐ Birth Records	☐ Complete Behavior Checklist
☐ Drug and Alcohol records	☐ Developmental History	☐ Two-way written Communications
☐ Lab Reports	☐ Mother's Prenatal Records	☐ Two-way verbal Communication
☐ Summary of Hospitalization Dates: _____		☐ Other: _____
		☐ 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 I will receive a signed copy of this completed authorization,
- 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 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,
- and that the release of records will be used for the purpose stated above.

I have read this form, it has been explained to me, and I understand its contents. This authorization remains in effect until _____ (no longer than 12 months). 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): _____
-or-
Signature of Parent/designated legal representative: _____

Relationship to Client (parent, guardian, power of attorney, etc.): _____

Printed Name: _____

Date: _____

Staff Signature: _____ Date: _____

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VERBAL AUTHORIZATION – NOT APPLICABLE TO HIV RELATED INFORMATION

I witness that the client (or designated 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: _____