

AUTHORIZATION TO RELEASE INFORMATION FORM
FOR INSURANCE PURPOSES

Patient Name: _____ Patient Date of Birth ___ / ___ / ___
Patient Address: _____

Information is being released to : (Your Insurance Company) _____

Specific information is to be released: Copy of Intake Report (first page), and Update Summaries of treatment progress, and copies of psychiatric reports.

Purpose for releasing information: Establishes reasons for providing insurance coverage of mental health services and for additional authorization of services.

I understand that my records are protected under Section 5100.34 of the Pennsylvania Mental Health Procedures Act and the Pennsylvania Drug and Alcohol Abuse Control Act, and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and can not be disclosed without my written consent unless otherwise provided for in state of federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(specification of date, event, or condition upon which this consent expires)

I, _____ hereby authorize Growth Opportunity Center to release the information stated above.

Patient: _____ Date: _____

Person Authorized in lieu of patient: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

Prohibition On Redislosure: Alcohol and Drug Abuse information has been disclosed to you from records who's confidentiality is protected by Federal Law, Federal regulations (42 CFR, Part 2) prohibits you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is no sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Copy of Release offered to Patient: Accepted _____ Rejected _____