PITTSBURGH PSYCHOTHERAPY ASSOCIATES, LLC
Wellness in Motion

9401 McKnight Road, Suite 105
Pittsburgh, Pennsylvania 15237

412-367-0575
www.PghPsychotherapy.com

Client Name:_____ Date of Birth: _____

Client Address: _____

Person or Organization with Whom Information can be Shared: please print legibly

Name/Organization: _____

Address:_____

Phone Number: _____

Fax Number: _____

Email Address (if applicable): _____

Types of Information to be Shared (check all that apply):

- ☐ Current Status and Location
- ☐ Billing Statements
- ☐ Assessment
- ☐ Dates of Treatment
- ☐ Diagnosis
- ☐ Discharge/Transfer Summary
- ☐ Emergency Contact
- ☐ Individual Service/TreatmentPlan
- ☐ Medication Regimen
- ☐ Nature of Treatment
- ☐ Prognosis
- ☐ Progress/Psychotherapy Notes
- ☐ Psychiatric Evaluation
- ☐ Other (please specify) _____

Purpose of Disclosure (check all that apply):

- ☐ Continuity of Care
- ☐ Emergency Management
- ☐ Account Management
- ☐ Other (please specify) _____

Duration and Revocation of Authorization

This authorization is good for a period of 1 year from the date of signature.
I understand that I can revoke this authorization at any time prior to that date by contacting the practice in writing.

I understand that if the practice has already shared the information authorized here at the time I revoke this authorization, then it is too late to prevent that information from being shared.

I understand that the practice cannot make completion of this authorization a condition for any treatments or benefits I am entitled to, unless this authorization is necessary to determine eligibility for treatment or benefits or to pay for treatments I receive.

I understand that this Authorization is effective for a period of one year from the date of the signature, unless otherwise specified. The time frame may not exceed one year from the date of signature.

I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that Pittsburgh Psychotherapy Associates, LLC has already acted upon it, or if this Authorization was signed as a condition of obtaining insurance coverage.

I understand that, in order to revoke this Authorization, I understand that I must revoke it in writing to Pittsburgh Psychotherapy Associates, LLC. Pittsburgh Psychotherapy Associates, LLC has forms for you to use to revoke this Authorization at any time before it expires.

I may refuse to sign this authorization and I understand that my refusal will not impact my ability to receive treatment from this practice.

I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me under the Health Insurance Portability and Accountability Act (HIPAA) regulations. For information related to substance abuse and/or HIV, state law prohibits making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.

FOR AUTHORIZATION FOR RELEASE OF SUBSTANCE ABUSE/TREATMENT, HIV RELATED, AND/OR MENTAL HEALTH INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania state and federal laws, including 42 C.F.R., each of which prohibit you from making any further disclosure 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 information is not sufficient for this purpose.

Authorization

I hereby authorize Pittsburgh Psychotherapy Associates, LLC to release information as described above to, and request information from, the person or organization identified herein. I understand that the person or organization named above may not be subject to the same privacy laws and regulations as Pittsburgh Psychotherapy Associates, LLC and may be able to further share the information disclosed under this authorization. I consent to use electronic signatures, and my signature below is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility. I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me under the Health Insurance Portability and Accountability Act (HIPAA) regulations. For information related to substance abuse and/or HIV, state law prohibits making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.

Client Name (Printed): _____

Client Signature: _____ Date: _____

Authorized Representative:

Name (Printed): _____

Signature: _____ Date: _____

Relationship to Client: _____