AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL INFORMATION

I, _____ of _____
(Name) (Number & street address)

_____
(City & State) (Zip code)

Date of birth: _____ Social Security Number: _____

Authorize:
MARK DEAN, MFA, MA, ATR-BC, LPC OR MICHELLE L. DEAN, MA, ATR-BC, LPC, CGP
(THE TREATING CLINICIANS)
AT THE CENTER FOR PSYCHE & THE ARTS, LLC
1137 E. Lancaster Ave., Berwyn, PA 19312, & 42 Windermere Ave., Lansdowne, PA 19050
telephone: 610.259.2550; email: contact@psychearts.org

( ) TO RELEASE
( ) TO OBTAIN

( ) Verbal Exchange
( ) Discharge Summary
( ) Admission Evaluation
( ) Psychiatric Evaluation
( ) History & Physical
( ) Other: _____
( ) All of the above

( ) Medical Records
( ) Psychological Testing & Evaluations
( ) HIV testing
( ) Medication Records

( ) Progress Notes
( ) Physicians Orders
( ) Laboratory Results
( ) Treatment Plan(s)
( ) Treatment Summary

To/From: Organization and/or Person: _____
Address: _____
Telephone number: _____
I hereby authorize the treating clinician at The Center for Psyche & the Arts, LLC to release/obtain copies of psychiatric, drug and alcohol, HIV and medical information
From the healthcare record pertaining to my hospitalization/treatment of _____
by mail, couriers, telephone conversation, or facsimile transmission to or from. (Specify dates of treatment)

THESE RECORDS ARE REQUIRED FOR THE PURPOSE OF: (CHECK AT LEAST ONE)
___ Providing information to health care providers
___ Legal purposes
___ Social Security/Disability
___ School guidance counselor, crisis support, and/or case manager to determine academic obligations, to review educational psychological, and/or intelligence testing.
___ Other: (specify) _____

PLEASE INITIAL THE FOLLOWING:
___ I understand that my healthcare and payment for healthcare will not be affected if I do not sign this form, and I am entitled to a copy of this form after I sign it.
___ I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion.
___ I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written and dated communication to the treating clinician at The Center for Psyche & the Arts, LLC

This information has been disclosed to you from confidential records protected by state and federal laws; those laws are more stringent will apply. Any further disclosure of this information is not permitted without specific authorization to do so.
I certify this form has been fully explained to me and I understand its contents.
Signature of Patient: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____
If parents are divorced, both parents must sign
Signature of Parent/Guardian: _____ Date: _____
Signature of Witness: _____ Date: _____
(Clinician's signature)
I herby acknowledge that I have been asked to sign the above release of confidential information and elect to REFUSE PERMISSION.
Signature of Patient: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____
Signature of Witness: _____ Date: _____
(Clinician's signature)

This form applies and remains in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).