SUMMIT PSYCHOLOGICAL SERVICES
1350 Old Freeport Road, Suite 1A Pittsburgh, PA 15238
Phone: 412-406-7734 Fax: 412-406-7742

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Summit Psychological Services to ☐Release and/or ☐Receive information from the record of:

_____ to
Patient Name *Date of Birth*

at

_____
Name of Doctor or Person *Name of Facility*

_____
Facility or Person's Address

_____
Phone *Fax*

for the purpose of:

☐Continuity of Care	☐Patient/Guardian Request	☐Other:

and to include only the below specified information:

☐Drug & Alcohol Information	☐Mental Health Information
☐EEG/EKG Reports	☐Outpatient Information
☐Emergency Dept. Reports	☐Physician Office Records (Medical History, Exams, Discharge Summary)
☐Evaluation Reports	☐Psychological of Neurological Evaluation, Notes, Discharge Summary
☐HIV-related Information	☐Psychiatric Evaluation, Medication Notes, Discharge Summary
☐Inpatient Records	☐Treatment and Crisis Plans/Summaries
☐Lab Results & Vitals	☐Two-way Written/Verbal Communication
☐Medication Lists	☐Other:

This release of information is to begin on _____, not to exceed a maximum of 1 year.
Today's Date

I understand that my signature below acknowledges the following:

- My information will not be released or obtained unless permission is provided by my signature or verbal authorization on this form, in effect for a period of one calendar year unless otherwise specified here: _____.
- Only the items checked off or listed above will be released, and only for the stated reason.
- I may refuse to sign this authorization, am entitled to a copy of this completed form, and have the right to revoke this authorization at any time with the understanding that:
  a) My decision to revoke the authorization does not apply to any records released prior to the date of revocation.
  b) My decision to revoke the authorization may result in in my insurance company's inability to pay for my medical care, and that the responsibility for payment of claims may fall to me.
- Neither Summit Psychological Services nor any other parties will condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person receiving my records may re-disclose my information. All staff and employees of Summit Psychological Services have no responsibility or liability as a result of re-disclosure, and such information will no longer be protected by federal privacy regulations.

_____ _____ _____ _____
Signature of Patient (14 years of age or older) *Date* *Signature of Witness/Staff Member* *Date*

_____ _____ _____
**Name of Parent, Legal Guardian, or Authorized Representative* *Signature of Parent, Legal Guardian, or Authorized Representative* *Date*

*Authorized Representative's relationship and authority to act on behalf of patient (POA, Guardianship, etc.):

Oral Authorization (for persons physically unable to sign): I witness that the patient understood the nature of this release, and freely gave their oral authorization. _____
Signature of Witness/Staff Member *Date*