Consumer's Name: _____

T.W. PONESSA & ASSOCIATES COUNSELING SERVICES, INC.

Corporate Office: 410 N. Prince St. Lancaster, PA 17603
(717) 560-7917 Fax: (717) 560-6452

AUTHORIZATION TO DISCLOSE / OBTAIN INFORMATION

*THIS HIPAA COMPLIANT FORM MUST BE COMPLETED IN FULL IN ORDER TO DISCLOSE/OBTAIN RECORDS FROM T.W. PONESSA & ASSOCIATES COUNSELING SERVICES, INC.

Consumer's Name: Date of Birth:

_____

Social Security #: XXX-XX- _____

I request and authorize: **T.W. Ponessa & Associates Counseling Services, Inc., 410 N. Prince St., Lancaster, PA 17603 (Corporate headquarters) and any of its satellite offices:** To **disclose/obtain** (circle one or both) my mental health/substance use disorder information of the consumer named above to/from: (please print and **must be completed in full).**

Name/Entity: _____

Address: (including city, state, and ZIP) _____

_____

Telephone #: _____ Fax #: _____

This request and authorization applies to (Check all that apply):

[ ] Treatment Plan
[ ] Medication Log
[ ] Psychiatric/Psychological Evaluations
[ ] Outpatient treatment summary
[ ] Discharge Summary
[ ] Verbal communication
[ ] Other: _____

[ ] 5 Areas Specified by State Regulation PA255.5
[ ] Presence in Treatment
[ ] Short statement regarding relapse into drug and alcohol abuse and frequency of such relapse
[ ] Consumer's prognosis (including diagnosis)
[ ] The nature of treatment
[ ] Brief description of the consumer's progress

For the period of _____ through _____; or [ ] ALL.

The records protected by state and federal laws and regulations, which are designed to protect the confidentiality of sensitive patient/client information, including without limitation, 42 Code of Federal Regulations Part 2, the Pennsylvania Confidentiality of HIV-Related Information Act, Mental Health Procedures Act, and Drug and Alcohol Control Act. 42 CFR Part 2 restricts any use of this information to investigate or prosecute any alcohol or drug patient for a crime.

Your protected health information, specifically sexually transmitted disease (STD) (as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, chancroid, lymphogranuloma venereum, HIV, AIDS, and gonorrhea) must be authorized to be released.

Consumer's Name: _____

[ ] Yes/ [ ] No – I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person/entity listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

For the receiver of this information: This information has been disclosed to you from records protected by Pennsylvania law and Federal law. Pennsylvania law and Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

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I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so verbally or in writing and present my written revocation to the record custodian of T. W. Ponessa. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy or for payment of services rendered by a health care provider.

Unless otherwise revoked, this authorization will expire in: [ ] one year from the date of signature [ ] 90 Days after discharge [ ] other, print the date _____

I understand that authorizing the release of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I can inspect the information to be used or disclosed as provided in CFR 164.524. I understand that any release of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by state/federal confidentiality rules. If I have questions about the release of my mental health records, I can contact the record custodian of the disclosing organization.

This information is disclosed/obtained for the purpose of (check all that apply):
[ ] continuity of care
[ ] legal
[ ] other, please specify _____

_____

Consumer's Signature (14 years of age or older) Date authorized

_____

Parent/Guardian Signature / Legal Representative Date authorized
(if consumer is less than 14 years of age)

_____

Witness Date authorized

Accept copy of this form: YES / NO

NOTICE: The following fee schedule (2022) applies to the retrieval and photocopying of medical records. Flat fee for production of records to support claims under the Social Security $31.94. Non-Social Security requests $25.20 search & retrieval fee; pages 1-20 $1.70 per page; pages 21-60 $1.26 per page; pages 61-end $0.44 per page.