Alepix Behavioral Clinic

MENTAL HEALTH SERVICES FOR ADULTS & CHILDREN
25 N. THOMPSON LANE, SUITE E, IRWIN, PA 15642
MAIN 724-382-4941 FAX 724-590-5121
www.alepix.com

Consent to Release/Obtain Confidential Information

Patient Name: _____ Date of Birth:_____ Insurance ID:_____

Alepix Behavioral Clinic has permission to:

☐ **Obtain information from:** ☐ **Release information to:**

_____
(Name of provider or individual)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone)

_____
(Fax)

I, _____, authorize the following information to be released for the purpose of diagnosis, treatment planning, continuity of care and/or case management:

Date Range: _____ to _____.

☐ Summary of Progress	☐ Therapy progress notes	☐ Laboratory testing	☐ Attendance
☐ Psychiatric Evaluation	☐ Treatment plans	☐ Diagnosis	☐ Medication progress notes
☐ Psychological Evaluation	☐ Academic/School reports	☐ Medications/Refills	☐ Other _____

Type of Communication: ☐ Verbal/Phone ☐Written ☐Fax ☐Email ☐Other _____

My Rights:

- I understand that in order to protect the confidentiality of my records, my agreement to obtain or release information is necessary and that this permission is limited to the purpose and to the person or organization listed above.
- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose were to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sough only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to this this authorization. I further understand that failure to sign this authorization may lead to a delay in medical treatment.
- This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment** and may contain information concerning **HIV testing and/or AIDS diagnosis or treatment.**

I have read this form, it has been explained to me, and I understand its contents. This authorization will remain in effect until the date indicated (no longer than 12 months). If no date is indicated, the authorization will expire one (1) year from the date this form is signed. **Date (if less than one (1) year): _____**

Patient Name:_____ DOB: _____ Insurance ID: _____
Patient signature: _____ Date: _____
Legal representative (if under 14): _____ Relationship: _____
Representative signature: _____ Date: _____
Alepix signature: _____ Date: _____