CHRISTIAN COUNSELING ASSOCIATES
OF WESTERN PENNSYLVANIA
Richard Hoffman Ph.D., Clinical Director

RELEASE OF INFORMATION

Patient's Name _____ Birth Date _____ ☐ Member's ID ☐ SSN ☐ Chart # _____

Street Address _____ City _____ State _____ Zip Code _____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information)Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for confidentiality of Alcohol and Drug Abuse Client Records) Title 42 of the code of Federal Regulations Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependence, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I also understand that my health plan may not condition treatment, payment enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in it health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying, Christian Counseling Associates of Western PA (CCA) in writing, but if I do, it will not have any effect on any actions CCA took before it received the revocation.

I hereby authorize CCA to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I hereby authorize CCA to exchange / release / obtain information:

☐ verbally only ☐ in written form only ☐ both verbally and in writing

Person/organization receiving/communicating the information:

Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone Number: (____) _____--_____ Extension _____ Email:_____

Description of Individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

- ☐ All
- ☐ Clinical records
- ☐ Attendance Only
- ☐ All pertinent documentation CCA deems appropriate for the purpose(s) checked below
- ☐ Other (describe): _____
- ☐ Treatment Plan(s)
- ☐ Outpatient Progress Reports

The Purpose of this release is (check all that apply):

- ☐ To allow the clinically appropriate management and coordination of the Clients mental health and/or substance abuse treatment
- ☐ Other (describe):

_____

The dates of records to be disclosed:

From _____ (MM/DD/YY) To _____ (MM/DD/YY)

THE CLIENTS OR CLIENT'S REPRESENTATIVE, MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:

☐ On _____(MM/DD/YY) or one year from the date of signature below

OR

☐ Once the following event occurs: _____

(***Form must be completed before signing***)

_____ _____ _____

Signature of Client/Legal Guardian | Signature of Minor Client | Date

_____ _____

Print Name of Client/Guardian | Relationship to the Client

_____ _____

Witness Signature | Date of Witness Signature

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

Initials: _____

A copy of this form has been requested and received:

☐ Yes ☐ No

Initials: _____ (Client)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Return Address:
101 Pembroke Ct.
Greensburg PA 15601
Fax: 724-972-4627
Email: ccawpa@gmail.com