CENTRA
PC
COMPREHENSIVE PSYCHOTHERAPY & CONSULTATION ASSOCIATES
5000 Sagemore Drive, Suite 205
Marlton, NJ 08053 856.983.3866 FAX 856.985.8148

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. PATIENT NAME _____ DATE OF BIRTH _____

2. INFORMATION TO BE DISCLOSED AND RELEASED:

_____All Records

_____Only the following information:_____

3. SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE

By signing my initials next to the specific category of highly confidential information, I am also expressly authorizing Centra PC to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above. I understand that Centra PC needs my specific authorization to release information pertaining to the items listed below.

____Mental/Behavioral Health Information

____Drug and Alcohol Treatment/Dependency Information

If you are authorizing the release of drug and alcohol records please note how much and what kind of information is to be disclosed:

_____

____HIV/AIDS Information

____Sexually Transmitted Disease Information

____Genetic Information

____Psychotherapy Notes

*(If you are authorizing the release of psychotherapy notes as well as other medical information, two separate forms must be filled out. The release of psychotherapy notes cannot be combined with the release of any other information.)

4. PURPOSE OF RELEASE: I authorize Centra PC to release my health information for the following specific purpose:

____At the request of the individual (i.e., the patient)

____To another healthcare provider

____For purposes of litigation

Pursuant to applicable federal and state law, I am aware of the privilege for confidential communication between a patient and a licensed mental health professional (e.g. psychiatrist, psychologist, therapist, counselor, social worker). I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.

PLEASE CHECK APPROPRIATE DISCLOSURE

_____RELEASE **_____OBTAIN**

I, (Patient) _____ **I, (Patient) _____**

Hereby authorize _____ **hereby authorize_____**
PROVIDER **PROVIDER**

Of Centra, P.C. to
Release information (checked above) to:

_____
_____
_____
_____
Release Date

Of Centra, P.C. to
Obtain information (checked above) from:

_____
_____
_____
_____
Release Date

The information to be disclosed from your records is confidential and protected by state and federal law. I understand that once Centra PC releases my health information to the recipient listed on this Authorization, Centra PC cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal or state law governing the use and disclosure of my health information.

I have read and understand the terms of this Authorization and have had the opportunity to ask questions about my rights to access my health information.

TERM/EXPIRATION: This signed Authorization will expire in **12 months** unless an earlier date is indicated by you below. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide written revocation to Centra PC's office at the address listed above. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not have any effect on any action taken by Centra PC in reliance of this Authorization before it received my written notice of revocation.

This Authorization will no longer be valid after: _____

I hereby authorize Centra PC to release/disclose the health information listed above for the purposes described in this Authorization.

Patient Signature: _____ **Date: _____**

Print Patient Name: _____

Witness Signature: _____ **Date: _____**

Print Witness Name: _____

If the patient is a minor or otherwise unable to sign this Authorization, then obtain the signature of the authorized representative/individual below:

Description of Authority: _____ Date: _____

Signature (other than patient): _____

NOTICE TO RECIPIENT OF INFORMATION

If the patient or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials above, the following Notice applies to the information you have received pursuant to this information: Alcohol and Drug Abuse information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.