

## Release of Information

I hereby authorize Gateway Rehabilitation Center – 100 Moffett Run Road, Aliquippa, PA 15001 (Phone (724) 378-4461 X-1172 or (Facsimile (724) 375-7956) to:

Select One:

- Disclose Information to the following Authorized Individual/Organization
- Receive Information from the following Authorized Individual/Organization
- Exchange Information with the following Authorized Individual/Organization

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Client ID \_\_\_\_\_

Authorized Individual/Organization (Name & Title: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Facsimile Number \_\_\_\_\_

- Purpose of Disclosure:**  Health Insurance Billing/Authorization  Continuity of Care  Collateral Contact Information
- Treatment Planning/Case Management  Continued Employment/Fitness for Duty  FMLA  Short Term Disability
- Other (Specify): \_\_\_\_\_

**Disclosure of information pertains to dates of treatment ranging from:**

(date) \_\_\_\_\_ - (date/"discharge") \_\_\_\_\_

**PA Code 255.5 limits the information that may be disclosed to Insurance Companies/Funding Source, Criminal Justice Systems/Government Agencies.**

**Is this Release of Information to an Insurance Company, School or Government Agency?**  Yes  No

***Mandated Treatment: I understand that this consent will remain in effect and cannot be revoked verbally or in writing until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceedings under which I may be court ordered or otherwise mandated into treatment.***

***If Yes, the Release of Information is limited to the following:***

- *Whether the client is or is not in treatment*
- *The Prognosis of the patient*
- *The nature of the project*
- *A brief description of the progress of the patient*
- *A short statement as to whether the patient has relapsed into drug or alcohol abuse and the frequency of such relapse.*

**Is the Release of Information to an Employer?**  Yes  No

***If Yes, the Release of information is limited to the following:***

- *Whether the client has or is receiving treatment*

**Is the Release of Information to an Employee Assistance Program?**  Yes  No

**If Yes, the Release of Information is limited to the following:**

- Evaluation Date and Recommendations
- Progress Letter
- Treatment Dates
- Monthly reports indicating compliance with recommendation(s)
- Discharge Status

**Other Release Type?** Yes No

**Specify the type of information to be disclosed (check all that applies):**

- To explain and/or answer questions pertaining to the Intake Process and/or Gateway Rehab services.
- To gather information to assist in my evaluation or social/psychological status including chemical use.
- Invite family members or concerned persons to participate in the Family Wellness Group,
- Notify family members or concerned persons listed of my progress during treatment and of my discharge.
- All of my substance use disorder information (including diagnoses, Progress Notes, and Diagnostic Assessment Information)
- None of my substance use disorder information
- All of my medications, including substance use disorder medications.
- All of my lab test results, including results related to substance use disorder.
- Diagnostic Assessment Information
- HIV/AIDS Testing or Status Pregnancy Testing
- Prenatal Care
- Diagnoses
- Discharge Summary/Planning Instructions
- Information on Mental Illness and and/or Treatment
- Presence in Treatment
- Letter of Treatment Verification (Dates of Treatment & Treatment Service)
- Bill and/or Payment related matters
- Insurance Cards
- Immunization Records
- Academic/School Records
- Demographics
- Other (Specify) \_\_\_\_\_

I understand that my records are protected 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 the regulations.

I also understand that I may revoke this consent verbally or in writing at any time except to the extent that information has been released prior to the date of revocation by contacting Medical Records. In any event, this consent shall expire one year from the date of signature.

Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C. F. R. Part 2.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Responsible Party Signature (If required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Copy Accepted Copy Refused