1 Hospital Dr
Aliquippa, PA 15001
Phone:724-857-9640

PINNACLE
TREATMENT CENTERS

Thank you for allowing Pinnacle Treatment Services of Aliquippa to assist with your medication needs while attending Gateway Rehabilitation Center. Your recovery and confidentiality are important to us. While attending Gateway, please be advised of the information we will need prior to your stay.

- Release of information between Pinnacle and the home clinic
- Release of information between Gateway and the home clinic
- Release of information between Pinnacle and Gateway (Please use forms attached)
- Completed guest dosing form (please use attached form)
- Letter guaranteeing return once discharged from Gateway (Please use attached form)
- Valid Photo ID present at the time of medication
- Copy of all insurance cards front and back
- EKG may be required upon medical review

Please submit completed packet to:

Pinnacle Treatment Services of Aliquippa

Fax: 724-857-9653 or Email: PTSAguestdosing@pinnacletreatment.com (secure email)

Gateway Rehab Center:

Phone: 724-378-4461 Fax: 724-375-3878 Email: Cas@gatewayrehab.org (secure email)

Thank you again for choosing Pinnacle Treatment Services of Aliquippa and Gateway Rehab for your treatment needs!

M. Rajendaran

Melissa Rajendaran MS, NCC, CAADC

Executive Director

PROHIBITION ON RE-DISCLOSURE OF CONFIDENTIAL INFORMATION

This notice is accompanied by a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressed, permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

Pinnacle Treatment Centers
Authorization to Release Medical Information

Patient Name	Date of Birth	Social Security Number
Address		

The above-named individual (or his/her legally authorized representative named below) authorizes and requests:

Name of Pinnacle Provider Entity:
Pinnacle Treatment Services of Aliquippa
Address of Pinnacle Provider Entity:
1 Hospital Drive, Aliquippa, PA 15001

the above-named provider to disclose and furnish the information requested below to the following person or organization and allows for two-way communication between both parties:

Name of Person or Organization Information is to be sent to:
Home: Clinic
Address:

The information to be disclosed includes the following [**check** all that apply]:

☐ General Medical Record (including, but not limited to, history & physical; physician, nurse and other provider notes; social work/case management notes; psychiatric/mental health/developmental disabilities information; consultation reports; X-ray, test and study results).

☐ Psychotherapy Notes.

☑ Alcohol/Drug Abuse Diagnosis/Treatment Information.

☐ AIDS/HIV/Related Illness Information.

☐ All Billing Records (Statements/Bills/Insurance Claim Forms, etc.).

☑ Other: Medication Records, EKG, recent hospital records

The date(s) of treatment/services to be released include: Admission through discharge

The purpose of the disclosure of the foregoing information is: coordination of care

My authorization to release the foregoing information expires [insert a date, event or condition]: 7 days post discharge

I understand the following:

1. This authorization may be revoked by me at any time in writing and/or verbally (such action verified in writing), except to the extent the above-named Pinnacle Provider Entity has already acted in reliance on this authorization. Acting in reliance includes, but is not limited to, the provision of treatment services in reliance on a valid consent to disclose information to a third party payer. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the HIPAA Privacy Officer of the Pinnacle Provider Entity named above, at the address set forth above. If not revoked by me, this authorization will expire upon the date or event noted above.
2. The Pinnacle Provider Entity cannot condition treatment on the signing of this authorization.
3. I have the right to inspect or receive a copy of the information sought to be disclosed or disclosed in this authorization as permitted under HIPAA and other applicable laws and regulations.
4. By signing this form, I am authorizing the Pinnacle Provider Entity named above to release and disclose medical information as described in this authorization.
5. A disclosure made by the above-named Pinnacle Provider Entity pursuant to this authorization will contain the written statement attached to this authorization.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Patient offered copy: ☐ Accepted ☐ Declined

Notice Accompanying Disclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit 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 as otherwise permitted by 42 C.F.R. Part 2. 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.

Pinnacle Treatment Centers
Authorization to Release Medical Information

Patient Name	Date of Birth	Social Security Number
Address		

The above-named individual (or his/her legally authorized representative named below) authorizes and requests:

Name of Pinnacle Provider Entity:
Gateway Rehabilitation Center
Address of Pinnacle Provider Entity:
100 Moffett Run Road, Aliquippa, PA 15001

the above-named provider to disclose and furnish the information requested below to the following person or organization and allows for two-way communication between both parties:

Name of Person or Organization Information is to be sent to:
Home Clinic:
Address:

The information to be disclosed includes the following [**check** all that apply]:

☐ General Medical Record (including, but not limited to, history & physical; physician, nurse and other provider notes; social work/case management notes; psychiatric/mental health/developmental disabilities information; consultation reports; X-ray, test and study results).

☐ Psychotherapy Notes.

☑ Alcohol/Drug Abuse Diagnosis/Treatment Information.

☐ AIDS/HIV/Related Illness Information.

☐ All Billing Records (Statements/Bills/Insurance Claim Forms, etc.).

☑ Other: Medication Records, EKG, recent hospital records

The date(s) of treatment/services to be released include: intake through discharge

The purpose of the disclosure of the foregoing information is: coordination of care

My authorization to release the foregoing information expires [insert a date, event or condition]: 7 days post discharge

I understand the following:

1. This authorization may be revoked by me at any time in writing and/or verbally (such action verified in writing), except to the extent the above-named Pinnacle Provider Entity has already acted in reliance on this authorization. Acting in reliance includes, but is not limited to, the provision of treatment services in reliance on a valid consent to disclose information to a third party payer. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the HIPAA Privacy Officer of the Pinnacle Provider Entity named above, at the address set forth above. If not revoked by me, this authorization will expire upon the date or event noted above.
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4. By signing this form, I am authorizing the Pinnacle Provider Entity named above to release and disclose medical information as described in this authorization.
5. A disclosure made by the above-named Pinnacle Provider Entity pursuant to this authorization will contain the written statement attached to this authorization.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Patient offered copy: ☐ Accepted ☐ Declined

Notice Accompanying Disclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit 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 as otherwise permitted by 42 C.F.R. Part 2. 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.

Pinnacle Treatment Centers
Authorization to Release Medical Information

Patient Name	Date of Birth	Social Security Number
Address		

The above-named individual (or his/her legally authorized representative named below) authorizes and requests:

Name of Pinnacle Provider Entity:
Pinnacle Treatment Services of Aliquippa
Address of Pinnacle Provider Entity:
1 Hospital Drive, Aliquippa PA 15001

the above-named provider to disclose and furnish the information requested below to the following person or organization and allows for two-way communication between both parties:

Name of Person or Organization Information is to be sent to:
Gateway Rehabilitation Center
Address:
100 Moffett Run Road, Aliquippa, PA 15001

The information to be disclosed includes the following [**check** all that apply]:

☐ General Medical Record (including, but not limited to, history & physical; physician, nurse and other provider notes; social work/case management notes; psychiatric/mental health/developmental disabilities information; consultation reports; X-ray, test and study results).

☐ Psychotherapy Notes.

☑ Alcohol/Drug Abuse Diagnosis/Treatment Information.

☐ AIDS/HIV/Related Illness Information.

☐ All Billing Records (Statements/Bills/Insurance Claim Forms, etc.).

☑ Other: presence in treatment, medication records, EKG

The date(s) of treatment/services to be released include: intake through discharge

The purpose of the disclosure of the foregoing information is: coordination of care

My authorization to release the foregoing information expires [insert a date, event or condition]: 7 days post discharge

I understand the following:

1. This authorization may be revoked by me at any time in writing and/or verbally (such action verified in writing), except to the extent the above-named Pinnacle Provider Entity has already acted in reliance on this authorization. Acting in reliance includes, but is not limited to, the provision of treatment services in reliance on a valid consent to disclose information to a third party payer. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the HIPAA Privacy Officer of the Pinnacle Provider Entity named above, at the address set forth above. If not revoked by me, this authorization will expire upon the date or event noted above.
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_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Patient offered copy: ☐ Accepted ☐ Declined

Notice Accompanying Disclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit 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 as otherwise permitted by 42 C.F.R. Part 2. 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.

Guest Dose Request

Form Prepared By:	Date Prepared:
Personal Data	
Patient Name: _____	
Birth Date: _____ Social Security #: _____ Ethnicity: _____	
Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____	
Visible Distinguishing Characteristics such as Tattoos etc.:	
Photo ID Attached Yes/No	**(Patient will NOT be dosed without Valid photo ID)**
Sending Clinic Treatment Information	
Home Clinic: _____	
Address: _____	
Telephone: _____	Fax Number: _____
Contact Staff Person(s): (for dose verification) _____	
Dose Amount (mgs): _____	Travel Dose Amount (mgs): _____
Last Date in Home Clinic: _____	First Date in Temp Clinic: _____
Last Date in Temp Clinc: _____	Date Back in Home Clinic: _____
Other Information:	
Travel Data: Guest Dose While Inpatient Rehab	
Temporary Phone Number: Gateway Rehab Main Campus	
Temporary Residence: 100 Moffet Run Road Aliquippa PA 15001	
Reason for Travel: Inpatient Rehabilitation	
Temporary Clinic Name: Pinnacle Treatment Services of Aliquippa	
Temporary Clinic Address: 1 Hospital Dr. Aliquippa PA 15001	
Temporary Clinic Telephone: 724-857-9640 Fax: 724-857-9653	
Contact Staff Person(s): (Nursing Dept): EXT 0249, 0546, 0547	
Temporary Clinic Hours: Mon-Fri 5-11am, Sat 6-9am	
COST: Please have your insurance card present at time of guest dose	

MEDICAL PHYSICIANS SIGNATURE: _____

DATE SIGNED: _____

Home clinic name:

Address:

Phone Number:

Fax Number:

Date:

Client Full Name:

Date of Birth:

To Pinnacle Treatment:

This letter is to verify that the above referenced individual has been a client under our maintenance program since their admission date on _____. It is our understanding that this individual is being referred to Gateway Rehabilitation Center Main Campus for inpatient treatment.

The above-named client is eligible to return to our program upon discharge from Gateway and will not be discharged while inpatient.

The above-named client is currently prescribed Methadone medication with a daily dose of _____.

Please contact us if you need any further information.

Sincerely,

Home Clinic Physician/Supervisor Name: _____

Home Clinic Physician/Supervisor Title: _____

Home Clinic Physician/Supervisor Signature: _____