

Welcome,

Gateway Rehabilitation Center has partnered with Pinnacle Treatment Centers of Aliquippa to assist with medication needs while attending inpatient treatment services. Prior to admission, Pinnacle will need the following information (please use attached forms):

- Release of information (2 way) from the home clinic to Pinnacle.
- Release of information (2 way) from the home clinic to Gateway.
- Release of information (2 way) for Pinnacle and Gateway.
- Letter guaranteeing return, once discharged from Gateway.
- Scanned copy of valid photo ID (must have this present for dosing).
- Copy of all insurance cards (front and back).

Once all forms, ID, and insurance card(s) are collected, please fax to Pinnacle Treatment Services directly at 724-857-9653 or securely send via email to <a href="https://example.com/PTSAguestdosing@pinnacletreatment.com">PTSAguestdosing@pinnacletreatment.com</a>. Please also send the entire Welcome Packet to Gateway Rehab Center, by either fax at 724-375-3878 or securely send via email to <a href="mailto:gatewaycas@gatewayrehab.org">gatewaycas@gatewayrehab.org</a>.

For any further inquiries, please contact us at:

Gateway Rehabilitation Center 100 Moffett Run Road Aliquippa PA 15001 724-378-4461 x2444

Pinnacle Treatment Services of Aliquippa 400 Woodlawn Road Aliquippa PA 15001 724-857-9640

Thank you.

Home clinic name:		
Address: Phone Number:		
Fax Number:		
Date:		
	a say as a man	
Client Full Name:	4.0	
Date of Birth:		
To Pinnacle Treatment Services:		
This letter is to verify that the above referenced individual has l	hean a client under our maintenance program	
since their admission date on It is our understand		
referred to Gateway Rehabilitation Center Main Campus for inp		
520		
The above-named client is eligible to return to our program upodischarged while inpatient.	on discharge from Gateway and will not be	
. to compare their control		
The above named client is currently prescribed Methadone Me	dication with a daily dose of	
Please contact us if you need any further information.		
Sincerely,		
±.		
	¥	
there elicis Dhyslains /Communication Atmosph		
Home Clinic Physician/Supervisor Name:		
Home clinic physician/Supervisor Signature:	<del></del>	
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		-
	The Community of the Co	
		41

### Home Clinic Name: Home clinic Address: Home Clinic Phone/Fax: Guest Medication

Form Prepared By:	Date Prepared:
Personal Data	
Patient Name:	
Birth Date: Social S	Security #:Ethnicity:
Height: Weight:	Hair: Eyes:
Visible Distinguishing Characteristics	s such as tattoos, etc.:
Photo ID attached Yes/No (Patient w	ill NOT be dosed without Valid photo ID)
Sending Clinic Treatment Information	i
Home Clinic:	i. i ii
Address:	
Telephone: ( )	Facsimile Number: ( )
Contact Staff Person(s): (for dose veri	fication)
Dose: mgs.	
Last Day in Home Clinic:	
First Day in Temp Clinic:	
Travel Dose Required:	
Other Information:	
×.	
Travel Data: Guest dose while input	tient rehab
Temporary Phone Number: Gateway I	The state of the s
Temporary Residence: 100 Moffet Ru	
Reason for Travel: Inpatient Rehabilit	ation
Temporary Clinic Name: Pinnacle Tre	eatment Services of Aliquippa
Temporary Clinic Address: 400 Wood	llawn Road Aliquippa PA
Temporary Clinic Telephone: (724-85	57-9640 ) Temporary Clinic Facsimile #: (724-857-9653
Contact Staff Person(s): (Nursing dens	ariment)
Temporary Clinic Hours:M-F 5-11am	Sat 6-9a_Temporary Clinic Med Hours: M-F 5-11am
Just: Please have your insurance car	a present at the time of guest dose
4edical Physician's Signature:	Date Signed:

### Authorization to Release Information

	Patient Name	Date of Birth	Social Security Number
	Address	<u> </u>	
The	above named individual (or his/her legally authorized repr	escntative named below) author	izes and requests:
	Name of Pinnacle Provider Entity: PTSA		
	Address of Pinnsele Provider Entity: 400 Woodlawn Road Aliquippa PA 15001 P: 724-8:		
thos	bove-named provider to disclose and furnish the informati	on requested below to the follow	ving person or organization:
	Name of Person or Organization Information is to be sent to:  Geteway Rehabilitation Center - Main Campus  Address:		
	100 Moffett Run Road Aliquipps PA 15001	<u> </u>	
The	information to be disclosed includes the following [check	all that apply]:	***
	1. Whether the client is or is not in treatment	-	
M	2. The prognosis of the client		
X	3. The nature of the project		
	4. A brief description of the progress of the client		
图-	5. A short statement as to whether the client has relapsed	nto drug or alcohol abuse and th	e frequency of such relapse
	5. All Billing Records (Statements/Bills/Insurance Claim	Forms, ctc.).	
	7. AIDS/HIV/Related Illness Information.		
	3. Psychotherapy/counseling notes		
	Other (explain): Admission date	<u> </u>	
The	inte(n) of trentmont/services to be released include: adm	ssion to discharge	<u> </u>
The	ourpose of the disclosure of the foregoing information is:	Coordination of care	
Mya	uthorization to release the foregoing information expires [i	asort a date, event or condition]:	discharge
permidesci	crstand the following:  This authorization may be revoked by me at any time if the above-named Pinnacle Provider Entity has already at mited to, the provision of treatment services in reliance on the Pinnacle Provider Entity cannot condition treatment. I have the right to inspect or receive a copy of the infointed under HIPAA and other applicable laws and regulated. By signing this form, I am authorizing the Pinnacle Priesed in this authorization. A disciouse made by the above-named Pinnacle Provided to this authorization. Information released to judges, probation or parole off al, under Pa.Code 255.5(1), (2), (4), (7), or (8) shall be res	sted in reliance on this authorize a valid consent to disclose information the signing of this authorizemation sought to be disclosed cons.  Evider Entity named above to recreate purpose authorize the significant to this authorizers, insurance companies, hear	tion. Acting in reliance includes, but is nation to a third party payer. cation, or disclosed in this authorization as lease and disclose information as zation will contain the written statement (th or hospital plan, or government
1	ACCEPT DECLINE a copy of this form.		

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 permits 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.

Patient Name:		<del></del>	
Patient Signature:	V/ 400 400	Date:	
Witness Name:			
Witness Signature:		Date•	

## Authorization to Release information

Patient Name	Date of Birth	Social Security Number
Address	<u></u>	9.
The Above named individual (or his/her legally suth	orized representative named be	elow) authorizes and requests:
Name of Pinnacle Provider Entity; Guteway Rehabilitation. Center - Main Campu. Address of Pinnacle Provider Entity:	6	
Run Road 100 Moffett Run road Aliquippa	PA 150	01
the above-named provider to disclose and furnish th		to the following person or organization:
Name of Person or Organization information is to be sent PTSA	t lo;	
Address;		
400 Woodlawn Road Aliquippa PA 15001		
The information to be disclosed includes the following	ing fahaals all that analyle	
<ul> <li>1. Whether the client is or is not in treatment</li> </ul>	tiff feneck air macabhtyl:	
2. The prognosis of the client		
3. The nature of the project		
4. A brief description of the progress of the clie	ent	
A chart statement as to whether the client has		abuse and the frequency of such relanse.
☐ 6. All Billing Records (Statements/Bills/Insurar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
7. AIDS/HTV/Related Illness Information.	and defined a second side j.	
S. Psychotherapy/counseling notes		
9. Other (explain): Admission date		
10 8. 1000	admission to discha	erne
The data(s) of treatment/services to be released inclu		
The purpose of the disclosure of the foregoing inform		
My authorization to release the foregoing information	expires finsert a date, event of	reonamonj: disonarge
extent the above-named Figure to Provider Entity has not limited to, the provision of treatment services in real. The Pinnacle Provider Entity cannot condition.  I have the right to inspect or receive a copy permitted under HIPAA and other applicable laws and the specific this service. I am authorizing the Polescribed in this authorization.	a thready noted in reliance on the cliance on a valid consent to did not treatment on the signing of of the information sought to be ad regulations.  Pinnacle Provider Entity named acle Provider Entity pursuant to	sclose information to a third party payer. This authorization. disclosed or disclosed in this authorization as above to release and disclose information as this authorization will contain the written statemen
official, under Pa.Code 255.5(1), (2), (4), (7), or (8) s	shall be restricted to the envine	spanes, meaning in negotial plan, or government rated categories set forth in 1-5 above.

This information has been disclosed to you from records protected by Rederal confidentiality rules (42 C.F.R. Part 2). The Pedical 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 periains 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 rederni rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Name:	<u> </u>	10	
Patient Signature:		Date:	
Witness Name:			
Witness Signature:		Date:	

	Patient Name	Date of Birth	Social Security Number
	Address		
The	L above-named individual (or his/her legally authorized repres	sentative named below) author	izes and requests:
	Name of Pinnacle Provider Entity: PTSA		•
	Address of Pinnacle Provider Entity,		
the	One Hospital Drive aliquippa PA 15001		
uic a	bove-named provider to disclose and furnish the information    Name of Person or Organization Information is to be sent to:	requested below to the follow	ving person or organization:
	Home Clinic:		
	Address: Home Clinic Address:		
	information to be disclosed includes the following [check al	l that apply]:	
	1. Whether the client is or is not in treatment		
	2. The prognosis of the client		
	3. The nature of the project		
<b>X</b>	4. A brief description of the progress of the client		
	5. A short statement as to whether the client has relapsed int		e frequency of such relapse
	6. All Billing Records (Statements/Bills/Insurance Claim Fo	rms, etc.).	
	7. AIDS/HIV/Related Illness Information.		
	8. Psychotherapy/counseling notes		
X	9. Other (explain): dosing records, methadone do	sage, last dose receive	d
The	date(s) of treatment/services to be released include: Admis	sion to Discharge	
The	purpose of the disclosure of the foregoing information is: Co	oordination for Gateway	y Rehab
Mya	uthorization to release the foregoing information expires [ins	ert a date, event or condition]:	Discharge
exter not li perm descr	lerstand the following:  1. This authorization may be revoked by me at any time in at the above-named Pinnacle Provider Entity has already acte mited to, the provision of treatment services in reliance on a second term of the Pinnacle Provider Entity cannot condition treatments. I have the right to inspect or receive a copy of the informitted under HIPAA and other applicable laws and regulation.  3. By signing this form, I am authorizing the Pinnacle Provided in this authorization.  3. A disclosure made by the above-named Pinnacle Provider need to this authorization.  4. Information released to judges, probation or parole official, under Pa.Code 255.5(1), (2), (4), (7), or (8) shall be restricted.	ed in reliance on this authorizated in reliance on this authorization the signing of this authorization sought to be disclosed os.  The continuous control of this authorization is authorization of the control of this authorization in the control of the control of this authorization in the control of	tion, Acting in reliance includes, but is nation to a third party payer, ation, r disclosed in this authorization as lease and disclose information as ation will contain the written statement th or hospital plan, or government
1	□ACCEPT □ DECLINE a copy of this form.		

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Pederal 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 cras 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 rederal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Name:	<u> </u>	
Patient Signature:	 Date:	<u></u>
Witness Name:	<del></del>	
Witness Signature:	 Date:	

	Patient Name	Date of Birth	Social Security Number
	Address		
77			
THE	above-named individual (or his/her legally authorized represented in Proposed Provider Entity:	sentative named below) author	izes and requests:
	Home Clinic:		
	Address of Pinnacle Provider Entity: Home Clinic Address:		
the a	bove-named provider to disclose and furnish the information	requested below to the follow	vina passan as association
	Name of Person or Organization Information is to be sent to:	requested below to the 101100	ving person or organization.
	PTSA Address		
	One Hospital Drive Aliquippa PA 15001 Phone: 72485796-	10 Fax: 7248579653	
		10 1 441 1210317033	
The i	information to be disclosed includes the following [check al	l that apply]:	
X	1. Whether the client is or is not in treatment		
	2. The prognosis of the client		
<b>X</b> 3	3. The nature of the project		
<b>X</b> 4	. A brief description of the progress of the client		
<b>X</b> 5	. A short statement as to whether the client has relapsed int	o drug or alcohol abuse and th	c frequency of such relapse
	i. All Billing Records (Statements/Bills/Insurance Claim Fo		
	AIDS/HIV/Related Illness Information.	•	
	. Psychotherapy/counseling notes		
	. Other (explain): dosing records, methadone do	sage, last dose receive	d
	late(s) of treatment/services to be released include: Admis	-	
	urpose of the disclosure of the foregoing information is:		v Rehab
	athorization to release the foregoing information expires [ins		
,	mornasion to release the foregoing mornasion expires [ms	erra date, event of condition]:	Dioditarge
1	anatomed share California		
1 extended not line 2 3 3 permi 4 descri 5 attach 6 6	erstand the following:  This authorization may be revoked by me at any time in a the above-named Pinnacle Provider Entity has already acterited to, the provision of treatment services in reliance on a way. The Pinnacle Provider Entity cannot condition treatment. I have the right to inspect or receive a copy of the informated under HIPAA and other applicable laws and regulations. By signing this form, I am authorizing the Pinnacle Provider in this authorization.  A disclosure made by the above-named Pinnacle Provider ed to this authorization.  Information released to judges, probation or parole office all, under Pa.Code 255.5(1), (2), (4), (7), or (8) shall be restricted.	d in reliance on this authorizated in reliance on this authorization the signing of this authorization sought to be disclosed of the control	tion. Acting in reliance includes, but is nation to a third party payer. ation.  r disclosed in this authorization as ease and disclose information as ation will contain the written statement the or bospital plan, or government.
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Patient Name:			
Patient Signature:		Date:	7 813
Witness Name:			
Witness Signature:	•	Date:	59 96 IS

	Patient Name	Date of Birth	Social Security Number
	Address		
	*10		
The	above-named individual (or his/her legally authorized repres	sentative named below) author	zes and requests:
	Nama of Pinnacle Provider Entity: Centucy Rehabilitation Cent	er - Main Camp	νις
	Address of Pinnucle Provider Entity: 100 Moffett Run Rd Higu:	ppa PA 15001	
the a	bove-named provider to disclose and furnish the information	n requested below to the follow	ring person or organization:
	Nume of Person or Organization Information is to be sent to:		
	Home clinic address:		
The i	nformation to be disclosed includes the following [check al		
	i. Whether the client is or is not in treatment	i unacappiyj:	
	. The prognosis of the client		
	The nature of the project		
	. A brief description of the progress of the client		
	. A short statement as to whether the client has relapsed int	n drug or algohol abuse and the	4 Francisco of grab values
	. All Billing Records (Statements/Bills/Insurance Claim Fo		e frequency of such retapse
	. AIDS/HIV/Related Illness Information.	11115, .Ctu. J.	
	Psychotherapy/counseling notes		
160	Other (explain):		
	ate(s) of treatment/services to be released include: Admis	sion to Discharge	
	urpose of the disclosure of the foregoing information is:		
	thorization to release the foregoing information expires [ins		Discharge
	and the state of the sold of the state of the states in s	cita date, event or condition]:	Discharge
1 extent not lir 2. 3. permi 4. descri 5. utiach	erstand the following:  This authorization may be revoked by me at any time in a the above-named Pinnacle Provider Entity has already acted to, the provision of treatment services in reliance on a tentity cannot condition treatment. I have the right to inspect or receive a copy of the informated under HIPAA and other applicable laws and regulations. By signing this form, I am authorizing the Pinnacle Provided in this authorization.  A disclosure made by the above-named Pinnacle Provider ed to this authorization. Information released to judges, probation or parole office II, under Pa Code 255.5(1), (2), (4), (7), or (8) shall be restricted.	ed in reliance on this authorizated in reliance on this authorizated in the signing of this authorizated in the signing of this authorizated in sought to be disclosed or solder Entity named above to relevant to this authorizates, insurance companies, health	ion. Acting in reliance includes, but is ation to a third party payer, ation.  disclosed in this authorization as case and disclose information as ation will contain the written statement bur hospital plan, or government
i [	ACCEPT DECLINE a copy of this form.		

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Patient Name:		<del></del>	
Patient Signature:	4	Date:	
		3	
Witness Name:			
Witness Signature:		'Date	

	Patient Nume	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: Home Chaic!					
	Address of Pinnagle Provider Entity: Home Clinic address:					
the above-named provider to disclose and furnish the information requested below to the following person or organization:						
	Name of Person or Organization Intermation is to be sent to: Clateury Kehabilitation Center - Main Campus					
	Address: 100 moffett Run Rd Aliquip	pa PA 15001				
The information to be disclosed includes the following (check all that apply):						
Ø;	2. The prognosis of the client					
☒ :	3. The nature of the project					
<b>X</b>	4. A brief description of the progress of the client					
<b>X</b> 5	i. A short statement as to whether the client has relapsed int	o drug or alcohol abuse and th	e frequency of such relanse			
	3. Psychotherapy/counseling notes					
<b>Z</b>	Other (explain):					
The date(s) of treatment/services to be released include: Admission to Discharge						
The p	surpose of the disclosure of the foregoing information is: Co	ordination of care				
Myn	uthorization to release the foregoing information expires [ins	ort a date, event or condition]:	Discharge			
	* M	•				
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.  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 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  6. Information released to judges, probation or parole officers, insurance companies, health or hospital plan, or government official, under Pa.Code 255.5(1), (2), (4), (7), or (8) shall be restricted to the enumerated categories set forth in 1-5 above.						
] 1	ACCEPT DECLINE a copy of this form.					

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Pederal 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 nederal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Name:			
Patient Signature:		Date:	
			16
Witness Name:	- A 101		
Witness Signature:		Date:	