



AUTHORIZATION FOR RELEASE OF INFORMATION -General Release-

Patient Name: _____

Client ID: _____ Admission Date: ____/____/____

Address: _____

Date of Birth: ____-____-____ Social Security Number: ____-____-____

Telephone Number: () ____-____ Email: _____

I, _____ hereby authorize Saint John Vianney Center, to release the following specific information pertaining to myself, by encrypted email, in person or by telephone contact. The information contained in my medical record may include treatment of physical and/or mental health, treatment of chemical dependency and/or alcohol abuse, testing results or treatment of communicable or infectious diseases.

The specific information to be released:

- | | | |
|---|---|---|
| <input type="checkbox"/> Admission Psychiatric Evaluation | <input type="checkbox"/> Comprehensive Inpatient Evaluation | <input type="checkbox"/> Physicians Orders |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Reports of Consultation | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Drug and Alcohol Information | <input type="checkbox"/> Laboratory Studies/EKG | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Treatment Narrative | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> TeleHealth Video Conferencing | <input type="checkbox"/> Continuing Care Summary | <input type="checkbox"/> Verbal Communication |
| | | <input type="checkbox"/> Scheduling |
| | | <input type="checkbox"/> Treatment Progress |
| | | <input type="checkbox"/> Discharge Planning |
| | | <input type="checkbox"/> Medical / Psychiatric Emergencies |

Purpose of Request: By patient request for knowledge of treatment and continuity of care. _____

All clinical reports will be sent by encrypted email to the email address noted below unless electronic transmission is unavailable. In this case, the report will be sent certified mail and return receipt.

Name/Facility: _____

Address: _____

Telephone: () ____-____

Email Address: _____

This authorization is valid from ____-____-____ to ____-____-____ (may not exceed one year).

I Understand:

- SJVC will not condition the provision of treatment or payment for care upon my signing this release.
- My consent is limited for the purposes and to the persons listed above.
- Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law (this is not applicable to those receiving D&A Treatment in accordance with PA Code 709.28).
- This release will be effective only during the dates listed above.
- I understand that this authorization, except for actions already taken, may be revoked by me at any time by communicating with any SJVC staff person in writing or verbally.
- By signing this release I acknowledge that I understand the form, have verified the information is correct and have been offered a copy of this consent form.

Patient Signature

Staff/Witness Signature

Date

Date