AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: Steven M. Murray

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

Address:_____

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

Telephone Number: ( ) 875 -_____ Email: jamesbe10@hotmail.com

---

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:

- ☐ Admission Psychiatric Evaluation
- ☐ History and Physical
- ☐ Drug and Alcohol Information
- ☐ Laboratory Studies/EKG
- ☐ Physicians Orders
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Neuropsychological Evaluation
- ☐ Reports of Consultation
- ■ TeleHealth Video Conferencing
- ■ Verbal Communication
  - ☐ ***Scheduling***
  - ☐ ***Treatment Progress***
  - ☐ ***Discharge Planning***
  - ☐ ***Medical / Psychiatric Emergencies***
- ☐ Comprehensive Inpatient Evaluation
- ☐ Psychosexual Risk Assessment
- ☐ Report of Polygraph
- ☐ Treatment Narrative
- ☐ Discharge Summary
- ☐ Wellness Plan (CC Services)
- ☐ Continuing Care Summary
- ☐ Other:

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 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 **Date** **Staff/Witness Signature** **Date**