Cranberry Psychological Center, Inc.

❑ **100 Northpointe Circle, Suite 306**
Seven Fields, PA 16046
Phone: (724) 772-4848 / Fax: (724) 772-4888

❑ **1340 Old Freeport Rd., 3r Fl**
Pittsburgh, PA 15238
Phone: (412) 406-8080 / Fax: (412) 406-8081
www.cranberrypsychcenter.com

❑ **3402 Washington Rd, Suite 304**
McMurray, PA 15317
Phone: (724) 941-5363 / Fax: (724) 941-5464

PATIENT NAME: _____
BIRTHDATE: _____

I have been a patient at Cranberry Psychological Center, Inc. or I am the patient's authorized representative. I understand that this facility has legally protected health information about me or the person that I represent. I understand that signing this form will not affect the treatment that I receive in any way. This authorization expires 1 year after the date signed, but I have the right to revoke this release at any time by sending a written request to the facility I have authorized to release the information..

I, _____, hereby authorize Cranberry Psychological Center, Inc. to
❑ obtain from and/or ❑ release to:

Name of Facility:_____
Attention:_____
Address: _____
City, State, Zip code: _____

❑ I give permission to fax to number: _____ ATTN:_____
❑ **I authorized the release of (please check all that apply): ___ mental health ___drug and alcohol information in any record requested.**

Information Authorized For Release:

❑ Psychiatric Evaluation	❑ Psychiatric Medication History	❑ Hospital Admission, Stay and Discharge Reports
❑ Psychotherapy Intake Assessment	❑ Psychological Testing	❑ Other (specify):
❑ Psychotherapy treatment record	❑ Letter/Report re: summary of treatment	❑ Other (specify):
❑ Treatment attendance record	❑ Report to satisfy specific court ordered request	❑ Other (specify):

From (*date*)_____ to (*date*) _____

Purpose of Request: ❑Continuity of Care
❑ Other (specify): _____

I release the above entity that disclosed this information from any legal responsibility or liability for disclosure of the above information to the extent that the information was used for its stated purposes. Information used by or disclosed to other organizations pursuant to this authorization may no longer be protected by our Privacy Rule, but further disclosure by organizations other than Cranberry Psychological Center, Inc. requires my additional signed release.

I understand that my records are protected under 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 regulation. I understand that I may revoke this consent verbally or in writing at any time except to the extent that the action has been taken in reliance on it. This authorization expires one year from date of signature, unless otherwise stated.

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 consistent with applicable law, including but not limited to, written or electronic format.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information without written authorization from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Signature _____ Date _____
(Patient aged 18 years or older ***OR*** Parent/Guardian of a minor child)

Signature _____ Date _____
(Signature of patient 14-17 years of age)

Signature_____Date_____
(Witness)