865 Eisenhower Blvd. Johnstown, PA 15904 Phone: (814) 266-8840 Fax: (814) 266-2176

Joshua Watt, Psy.D.
Ian Goncher, Psy.D.
Tracy Tredennick, LCSW
Danielle Hay, LSW
Brian McLeary, LPC
Prudence Shaulis, LPC

Pediatric Care Specialists
Behavioral Health Services

Ashley Goncher, LPC
Jamie Montag, LPC
Crystal Simms, MA
Kerri Lafferty, MA
Erin Shutty, MS
Lauren Erickson, MS

www.mybehavioralhealth.com

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

_____ _____
Name of Patient Date of Birth

I, _____, hereby authorize **Behavioral Health Services** to: ( ) send ( ) receive ( ) to ( ) from the following agency or person:

Name: _____
Address: _____
_____
Phone: _____

Authorization for release by means of: ( ) verbal ( ) mail ( ) fax

INFORMATION TO BE RELEASED:

_____ Psychological Reports / Evaluations
_____ Psychological Therapy Attendance Records
_____ Psychiatric Evaluations
_____ Other
_____ Psychological Therapy Progress Notes
_____ Psychological Treatment Plan
_____ Verbal Communication between Agencies

PURPOSE FOR NEED OF DISCLOSURE

_____ At the request of the individual
_____ Continuation of Care / Treatment Planning
_____ Other: _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand I have the right to:

1) Receive a copy of this authorization
2) Refuse to sign this authorization without impacting my treatment, payments, or operations
3) Revoke this authorization (will not apply to information that has already been released)

This authorization will remain in effect for one year from the date of signature.
By signing this release, I authorize the release of the specified information and cannot hold Behavioral Health Services responsible for any / all information released at my request.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

_____Witness

Verbal Consent Obtained: _____ _____ _____