



475 Morgan Highway
Scranton, PA 18501
(570)348-1482
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**AUTHORIZATION FOR RELEASE OF PSYCHIATRIC/PSYCHOLOGICAL
DRUG OR ALCOHOL INFORMATION**

I hereby authorize Allied Services Rehabilitation Hospital to release information from the medical records of:

Patient's Name (please print)
This information is to be released to:

Person or organization

Address

for the purpose of _____

I understand that the information includes psychiatric/ psychological, alcohol or drug information. The following portions of the record to be released are: _____

Itemize portions of medical record and time period

"This information has been disclosed to you from records whose confidentiality is protected by state statute. State regulations limit your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains."

"This information has been disclosed to you from records protected by federal confidentiality rules. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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."

I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon, and that this consent will remain in force for a period of ninety (90) days in order to effectuate the purposes for which it was given.

Date of Signature

Patient Signature

Witness

Signature of Responsible Party (when applicable only)
(Relationship to Patient)