THE MAURIELLO GROUP

BEHAVIORAL HEALTHCARE | CONSULTATIVE SERVICES | IN-SERVICE TRAININGS

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND PROTECTED HEALTH INFORMATION

I am completing this form to allow the use and sharing of confidential records and protected health information about:

Patient / Client Name: ____
Address: ____
Phone: _____________________ Birthdate: _______________ Social Security #: ________________________
Parent / guardian (if applicable): ____

A. I, the above-identified client/patient and/or client/patient representative, hereby authorize my treatment provider(s) and other appropriate staff at *Matthew J. Mauriello, MA, P.C.* (DBA "The Mauriello Group") to use, to disclose, and/or to receive the following protected health information (PHI) for coordination services between other treatment providers, billing purposes, and/or other necessary correspondence to improve my response to treatment and/or allow for other healthcare operations:

- ❑ Inpatient or outpatient treatment records for medical, physical, psychological, and/or psychiatric conditions
- ❑ Inpatient or outpatient treatment records for drug and/or alcohol abuse
- ❑ Admission and discharge summaries
- ❑ Psychological, psychiatric, counseling, or social work evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, testing records, psychometric data, behavioral observations, and/or checklists completed by any staff member, and/or healthcare provider, and/or the patient/client, and/or patient/client representative(s)
- ❑ Treatment, recovery, rehabilitation, aftercare plans, and/or other similar plans
- ❑ Progress in and response to treatment(s)
- ❑ Treatment, social, family, educational, and vocational histories
- ❑ Progress, nursing, case or similar notes
- ❑ Evaluations and reports of consultants
- ❑ Information about how the patient's/client's condition(s) affects or has affected his or her ability to work, to function, to attend school, to socialize, and/or to complete tasks or activities of daily living
- ❑ Vocational evaluations and reports
- ❑ Billing records, including payments, receipts, or insurance claim and benefit information
- ❑ Academic and educational records, including grades, results of achievement tests or standardized tests, reports of teachers' observations, classroom accommodations, 504 plans, Individual Education Plans (IEPs), and all other school or special education documents
- ❑ HIV-related information
- ❑ Legal records, including criminal record of arrests, charges, and/or convictions
- ❑ Complete copy of the medical record
- ❑ Other: ____

To this person(s) and/or organization(s):____
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B. I further authorize the person(s) and/or organization(s) named above to speak by telephone with my treatment provider(s) and other appropriate staff at *Matthew J. Mauriello, MA, P.C.*, about the reasons for the treatment referral, treatment history or diagnoses, and other similar information that can assist with my, the above-identified client/patient, receiving treatment or being evaluated or referred elsewhere.

C. I understand that no services will be denied me, the above-identified client/patient, solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I

believe that they are necessary to assist in the development of the best possible treatment plan for me, the above-identified client/patient. The information disclosed may be used in connection with my, the above-identified client's/patient's treatment.

D. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191 and The Family Educational Rights and Privacy Act (FERPA; 20 U.S.C. § 1232g; 34 CFR Part 99). It is also in compliance with Pennsylvania's Mental Health Procedures Act (MHPA) of 1976, 50 P.S. § 7101 *et seq.*, the Drug and Alcohol Abuse Control Act, 71 P.S. § 1690.101 *et seq*, the Confidentiality of HIV-related Information Act, 35 P.S. § 7601 *et seq*, and the Criminal History Record Information Act (CHRIA), 18 Pa. § 9101 *et. seq*.

E. Regarding this authorization, I hereby release the source of the records (i.e., *Matthew J. Mauriello, MA, P.C.*) from any and all liability arising there-from, including the potential re-disclosure of PHI by the recipient person(s) and organization(s).

F. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me, the above-identified client/patient, and arising out of an accident, injury, or occurrence to me, the above-identified client/patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 365 days from the date I signed it.

G. I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

H. I have been informed of the risks to privacy and limitations on confidentiality regarding the use of electronic means of information transfer (e.g., e-mail, text messages), and I accept these.

I. I understand that certain federal regulations bar secondary dissemination or re-disclosure of certain records (e.g., copyrighted information) or third-party documentation containing PHI.

J. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request. My signature below confirms my request and authorization to release PHI.

______________________	______________________		____________
Signature of client (if age 14 or older)	Printed name		Date
Signature of parent/guardian/representative	Printed name	Relationship	Date
Signature of parent/guardian/representative	Printed name	Relationship	Date

K. I, a behavioral healthcare professional, have discussed the issues above with the above-identified client/patient and/or his or her parent/legal guardian/personal representative. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed consent and authorization for release.

______________________	______________________	____________
Signature of professional	Printed name of professional	Date