The Children's Institute
Amazing Kids. Amazing Place.

Authorization for the Release of Information

Patient/Client Information			
Name			
Phone Number		Birth Date	

I Authorize The Children's Institute To: ☐ Release Information To: ☐ Obtain Information From: ☐ Exchange Information With:			
Organization/ Department			
Individual Name (If Applicable)			
Mailing Address			
Phone		Fax	
Email Address			

Release Applies to the Following Program(s):		
☐ Autism Services (ABA)	☐ Behavioral Health Services	☐ Care Coordination Services
☐ Early Intervention Services	☐ Family Support Services	☐ Physical Health Services
☐ Other (Please Specify):		

Information to Be Released/Obtained/Exchanged:		
☐ Evaluations/Assessments	☐ Treatment Plan/ Care Plan	☐ Visit Notes
☐ Progress Updates	☐ Discharge Summary	☐ Medication Records
☐ Videos/Pictures	☐ Billing Records	☐ Entire Record
☐ Verbal Discussion		
☐ Other (Please Specify):		

For Drug and Alcohol Records, Please Further Identify Specific Information to be Disclosed:		
☐ Relapse Information	☐ Prognosis/Diagnosis	☐ Client Progress
☐ Whether Client is in Treatment	☐ Nature of the Project	
☐ Other (Please Specify):		

Purpose(s):		
☐ Continuity of Care	☐ Attorney/Legal	☐ Personal
☐ Disability/SSI	☐ Insurance	☐ Do Not Wish to Disclose
☐ Other (Please Specify):		

Release of Special Protected Information	
I authorize the Children's Institute to release the following:	
☐ Behavioral Health Information	☐ Drug and Alcohol Information
In accordance with Pennsylvania's Act 147 of 2004, a parent or legal guardian's releasing records of minors ages 14-17 is limited to direct release from a mental health treatment provider to another treatment provider or to a primary care provider.	In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released in certain situations may be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

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Expiration Date	
This authorization will expire one (1) year from the date of signature, unless otherwise indicated.	
If applicable, specify other expiration date/event:	

Important Information
I understand that I can revoke or cancel this authorization at any time, but this does not apply to records that were already released. If I choose to revoke this authorization, I must notify the Children's Institute in writing.
I understand that the Children's Institute will not condition my or my child's treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.
I understand that The Children's Institute cannot control how the recipient uses or shares the information and that laws protecting its confidentiality may or may not protect this information once it has been released.
Information Specific to Release of Drug and Alcohol Records: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. A general authorization by the release of medical or other information is not sufficient.
Records requests can be sent to: The Children's Institute of Pittsburgh, Attn: Patient Access 1405 Shady Avenue, Pittsburgh, PA 15217 Phone: 412.420.2400 Fax: 412.420.2537

Signatures	
Patient/ Client or Parent/Legal Guardian Signature	Date
Patient/ Client or Parent/Legal Guardian Name	Relationship to Patient
Team Member Signature	Date
Team Member Name	Team Member Title
PLEASE NOTE: Clients 14 years and older may authorize the release of behavioral health records.	

Verbal Authorization (Not Permitted for Drug and Alcohol Records)	
Name of Patient/ Client or Parent/Legal Guardian Providing Authorization	Relationship
Witness Signature	Date
Witness Signature	Date