PSYCHOTHERAPY ASSOCIATES: *RELEASE OF INFORMATION*

1200 Ashwood Drive, Suite 1201, Canonsburg, PA 15317 2275 Swallow Hill Rd., Pittsburgh, PA 15220
724-884-0466 Office number (both locations)
fax 724-649-0039 Canonsburg/ Mt Lebanon

I authorize Provider_____
at *Psychotherapy Associates* to disclose and collaborate with Provider:

Name/Position_____
Address _____
Phone/Fax_____
Email _____

Regarding: Client name: _____
Date of Birth _____

Reason for disclosure:_____

Information to be disclosed:

_____

_____

_____

I understand that this authorization can be revoked at any time to the individual/organization in the above statement. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

Psychotherapy Associates, its programs, employees, officers, and contractors, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Information released will stay within the guidelines for HIPPA for the treatment of mental health records. Request for those HIPPA guidelines can be provided upon request.

This authorization expires
_____once acted upon _____ other (specify)_____

Signatures

Client_____Date_____

Witness_____Date_____

Parent/Guardian (if minor)_____Date _____

Revised 4/2017