GRAPEVINE CENTER INCORPORATED

140 North Elm Street, Suite B
Butler, PA. 16001-4820
Phone: (724) 283-1704
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Client Name: ______________________________ Date of Birth: ____/____/____

I hereby request and authorize Grapevine Center Inc. (Name of Facility/Person) 140 North Elm Street, Suite B Butler, PA. 16001-4820 (Facility Address)

To ☐ **Request** ☐ **Release** the following information **to/from** ______________________ (Name of Facility/Person) ______________________ (Facility Address)

These records are requested for the purpose of:
☐ Collaboration and coordination of services ☐ Assessment and/or Service Planning ☐ All of the above
☐ Recommendations ☐ Other: ______________________
Please include approximate dates of service for information being requested: ______________________

The records to be released (identify all that apply) are:

☐ Psychiatric Evaluation	☐ Psychological Evaluation	☐ Medication Evaluation & History
☐ Treatment History & Recommendations	☐ Social History	☐ Intake/Assessment
☐ Brief Description of Progress	☐ Synopsis of Prognosis/Diagnosis	☐ Presence in Tx. (Admit/Discharge Dates)
☐ Verbal Communications	☐ Other (Specify):	

* HIV-related information and drug and alcohol information contained in the parts of the record indicated above will be disclosed through this authorization unless otherwise indicated. Do not Release: ☐ HIV | ☐ Drug & Alcohol

The authorization shall be in effect for a period of ______________________

I understand the following:

- I have the right to revoke this Authorization at any time in writing, except to the extent that action has already been taken.
- Grapevine Center, Inc. has forms for you to use if you wish to revoke this Authorization at any time before it expires.
- The information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me by law.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall 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.
- Grapevine Center, Inc. may not require that I sign this Authorization in order to obtain treatment.
- I am entitled to a copy of this completed Authorization form: ☐ ACCEPTED | ☐ DECLINED Client Initials: ________

I have read this authorization, or had it explained to me, and I understand its contents.

Signature: ______________________ (Client/Legal Representative Signature) ____/____/____ Date:

If you are the legal representative of the person listed above, please check off the basis for your authority:

☐ Parent of Minor ☐ Guardianship Order (copy must be in chart) ☐ Power of Attorney (copy must be in chart) ☐ Other: ______________

Staff/Witness Signature: ______________________ Date: ______________

Witness Signature: ______________________ Date: ______________

(TWO witnesses are required for oral authorizations or when the client is physically unable to sign)

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

(Release of Information 9/29/21 RCB)