CORNERSTONE COUNSELING CENTER, PC
6011 JONESTOWN ROAD
HARRISBURG, PA 17112
Phone 717-671-9520
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name ________________________________ Date of Birth ________________________

I,____, by my signature below, do hereby consent and authorize Cornerstone Counseling Center, PC, to disclose to/receive from ______________________________ protected health information from my record(s) related to my identity, diagnosis, prognosis, and/or treatment (including diagnosis and/or treatment for substance abuse). The specific information to be disclosed includes but is not limited to (include dates where appropriate):

_____**Patient Data Form**	_____**Referral/Summary Letter**	_____**Complete copy of medical record**
_____**Initial Evaluation**	_____**Psychological/Ed. Evaluation**	_____**Other**_____________________
_____**Treatment Summary**	_____**Discharge Summary**	

I understand that this information is to be used for the purpose of:

____

____

I understand and agree that this Authorization will be valid and in effect until six (6) months after discharge from treatment unless otherwise specified: ________________. I understand that I can revoke this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date. I further understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I have read this form and understand what it means

Patient's Signature ____________________________________ Date____________________

Personal Representative's Signature __________________________________ Date____________________

Description of Representative's Authority ____

Witness Signature_______________________________________ Date_____________________

Copy offered: ____ refused ____ accepted