

Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services

Specific Exclusions: _____

NOTE: If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed. This information has been disclosed to you from records protected by Pennsylvania Law.

NOTE: If this Authorization is for marketing purposes, please note the following: The organization authorized to use or disclose my protected health information will or will not receive direct or indirect compensation for the use or disclosure of my information.

Expiration of Use and Disclosure of Protected Health Information

This Authorization expires [insert date or event] if less than ninety days: _____

Patient Rights Regarding Protected Health Information

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address: **St. Clair Medical Group Fatigati/Nalin Associates, 733 Washington Road, Suite 401, Pittsburgh, PA 15228**

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I understand that a fee may be assessed to process this request.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

Patient / Patient Representative Signature

Date: _____

Time: _____ AM / PM

Signature: _____

(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: _____

Verbal response given (patient physically unable to give written consent)

A verbal consent requires two (2) witness signatures. I witness that the patient (or responsible party) is definitely unable to provide a signature at this time but understands the nature of the release and freely gives his/her consent.

Witness

_____/_____/_____
Date

Witness

_____/_____/_____
Date