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Chambersburg Office:
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 Chambersburg, PA 17201
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Authorization to Release Healthcare and/or Educational Information

Patient Name:		Date of Birth:	
I hereby authorize Cognitive Health Solutions, LLC to:		<input type="checkbox"/> Release to	<input type="checkbox"/> Obtain from
Person or Facility:			
Person or Facility Phone #:		Person or Facility Fax #:	
Person or Facility Address:			
<input type="checkbox"/>	All available information and records may be released to and received from the individual/facility listed above.		
<input type="checkbox"/>	Verbal Communication	<input type="checkbox"/>	Contact, scheduling, & demographic information
<input type="checkbox"/>	Education goals, planning, records, and testing	<input type="checkbox"/>	All information necessary for payment/insurance
<input type="checkbox"/>	Legal history/involvement with court system	<input type="checkbox"/>	Professional observations, opinions, and impressions
<input type="checkbox"/>	Laboratory tests with imaging results (ex. X-ray MRI)	<input type="checkbox"/>	Medication History and evaluation(s)
<input type="checkbox"/>	Psychological/Psychiatric testing, evaluation, diagnosis, treatment, and recommendation information		
<input type="checkbox"/>	Other (specify):		
For the purpose of: <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Treatment Planning <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Other:			

You have the right to revoke this authorization, in writing, at any time by sending a written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer have a legal right to contest a claim.

I understand that the information in my health care record may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

I understand that services are not conditioned upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule. This consent will expire: One Year .

It is our policy that we obtain consent from both the adolescent and his or her parents/guardians. All signatures are required below, unless otherwise defined by a custody agreement in which case a copy of this agreement is required.

_____ Signature of Adolescent Patient	_____ Date
_____ Signature of Mother/Legal Guardian #1	_____ Date
_____ Signature of Father/Legal Guardian #2	_____ Date

To Recipient: This information has been disclosed to you for your records alone. Confidentiality is protected by Federal Law. Federal Regulation 42FR, part 2, prohibits you from making any further disclosure of this information, in writing or otherwise, without the specific written consent of the person whom it pertains or as provided by such regulations.