Main Office (Hanover):
100 West Eisenhower Drive, Suite A
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

York Office:
2500 Kingston Road, Suite 1
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

Chambersburg Office:
550 Cleveland Avenue, Suite 101
Chambersburg, PA 17201
Phone: (717) 446-0232
Fax: (717) 632-9300

Authorization to Release Information to Physician/Psychiatrist

Patient Name: Date of Birth:

I hereby authorize Cognitive Health *Solutions*, LLC to: ☐ Release to ☐ Obtain from

Person or Facility:

Person or Facility Phone #: Person or Facility Fax #:

Person or Facility Address:

☐ I **DECLINE** CHS to obtain/ release information with my PCP for the continuity of my care.

☐ I **ALLOW** CHS to obtain/release information with my PCP for continuity of my care (specifications below)

☐	**All available information and records (all of the information listed below, including, but not limited to, mental health and substance abuse information) may be release to and received from the practice listed above**		
☐	Psychological/Psychiatric evaluation, diagnosis, treatment, and recommendation information	☐	Contact, scheduling, & demographic information
☐	Laboratory tests with imaging results (ex. X-Ray, MRI)	☐	Professional observation, opinion, and impression
☐	Intake, family/social history, and treatment history	☐	Medication history, prescriptions, medical diagnosis, medical treatment
☐	Substance abuse assessment and treatment information	☐	Achievement/Educational Records
☐	Legal history/involvement with the court system		
☐	Other (specify):		

For the purpose of: ☐ Continuity of Care ☐ Treatment Planning ☐ Discharge Planning ☐ 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.