Authorization for Use and Disclosure of Protected Health Information

Date of Birth: _____ **Policy Number:** _____

I _____ (Consumer/Guardian/Parent), authorize Pinnacle Point Supportive Services, LLC to disclose private health information to and/or from_____ (Agency or Person to whom requested use or disclosure will be made) effective on the date of my signature.

Reason for Information to be released: _____

I consent to the release of information or records created by disclosure to and from PPSS pertaining to:

_____ Person Centered Plans/Treatment Plans
_____ Crisis Plan
_____ Service Notes/Reports/Updates
_____ School records
_____ Psychological Reports
_____ Immunization/Medical Reports
_____ Assessments
_____ Admission/ Discharge Information
_____ Guardianship Papers
_____ Written & Verbal communications pertinent to Treatment
_____ Other (Pleases be specific): _____

_____ I understand that the information disclosed may have been created by PPSS or released to PPSS by other agencies (i.e. re-release)
_____ I understand that information disclosed regarding my treatment may include (if applicable) information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).
_____ I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that PPSS cannot deny or refuse to provide services.
_____ I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing.

If not revoked earlier, this authorization expires on: _____ (not to exceed one year from the date of the signature).

_____
Consumer Name (please print)

_____ _____
Consumer Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Pinnacle Point Staff Signature Date

Initial _____ I do not want to release my information to anyone at this time.