



The Stern Center
for Developmental and Behavioral Health

**Authorization to Release Healthcare Information
to The Stern Center, Inc.**

PLEASE READ CAREFULLY

Patient's Name: _____

Date of Birth: _____ Social Security #: _____

Parent/Guardian's Name: _____

I request and authorize _____
to release healthcare information of the patient named above to:

**The Stern Center for Developmental and Behavioral Health, Inc.
110 South Arch Street
Connellsville, PA 15425**

This request authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:

- Current treatment plan, medications, and related information:

- All healthcare information.
- Other: _____

HIPPA ACKNOWLEDGMENT

I have received the Notice of Privacy Practices for The Stern Center for Development and Behavioral Health as described in the Health Insurance Portability and Privacy Act (HIPAA).

**The Stern Center is authorized to use and disclose health information about
_____ for treatment, payment, and
(patient name)**

healthcare operation purposes consistent with its Notice of Privacy Practices.

- I understand the potential that information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and is no longer protected by 45 CFR Part 164.508(c) (2).**

Definition:

- Yes **I authorize the release of records regarding drug, alcohol, or mental health treatment to The Stern Center for Developmental and Behavioral Health, Inc.**
- No

Patient Signature (14 years or older): _____ Date: _____

Parent Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.
THIS AUTHORIZATION IS REVOCABLE IF REQUESTED IN WRITING.