



Medical Information Release Form
(HIPAA Release Form)

Patient's Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and information of claimers. This information may be released to:

Spouse – Name: _____

Child(ren) – Name: _____

Father – Name: _____

Mother – Name: _____

Other – Name: _____

Information is to be NOT to be released to anyone unless required by law

RELEASE OF INFORMATION FOR MEDICAL ENTITIES

Behavioral Health: _____ Phone Number: ____ - ____ - ____

Caseworker: _____ Therapist: _____

Drug/Alcohol Entity: _____ Phone Number: ____ - ____ - ____

Caseworker: _____ Counselor: _____

County Drug / Alcohol: _____

*Mandatory to Release to County for Funding Issues, in the effort to attempt to resolve immediately

RELEASE OF INFORMATION FOR PROBATION/PAROLE

Probation/Parole Officer: _____

County: _____ Drug Court Liaison: _____

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY PATIENT IN WRITING



378 West Chestnut St. Suite 103
Washington PA, 15301
Office: 412.660.7064
Fax: 724.249.2825

Patient Information

Name: _____ Phone Number: ____ - ____ - ____ Home Cell Other

Email Address: _____

Consent to Deliver Appointment Reminders by: Voicemail Text Messaging Email

Date of Birth: ____ - ____ - ____ Social Security Number: ____ - ____ - ____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Full-Time Part-Time Seasonal

Address: _____

City: _____ State: _____ Zip Code: _____

PRIMARY Insurance Company: _____

Medicaid Medicare Commercial Other _____

Policy Holder Name: _____

Relationship to Policy Holder: Self Other _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Phone Number (Listed on Back of Card) ____ - ____ - ____

SECONDARY Insurance Company: _____

Policy Number: _____ GROUP NUMBER: _____

Assignment of benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical and private insurance and any other health plans to Positive Recovery Solutions LLC. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Patient Signature: _____ Date: ____/____/____



378 West Chestnut St. Suite 103
Washington PA, 15301
Office: 412.660.7064
Fax: 724.249.2825

Patient Medical History

Patient's Name: _____ Date of Birth: ____/____/____

Known Medical History

- Hepatitis A Yes No
- Hepatitis B Yes No
- Hepatitis C Yes No
- Elevated Liver Enzymes Yes No
- HIV and/or AIDS Yes No

Allergies: _____

Hospitalizations: _____

Patient Signature: _____ Date: ____/____/____

PRS Medical Staff Signature: _____ Date: ____/____/____



Patient's Name: _____

Date: ____/____/____

378 West Chestnut St. Suite 103
 Washington PA, 15301
 Office: 412.660.7064
 Fax: 724.249.2825

Substance Abuse Intake

	Date of Last Use	Quantity (Current or Peak Use)	Not Applicable
Tobacco			
Alcohol			
Cocaine			
Heroin			
Amphetamine			
THC			
Methadone			
Buprenorphine			
Opioid Medication			
Benzodiazepine			
Ecstasy			
Other:			
Other:			



378 West Chestnut St. Suite 103
Washington PA, 15301
Office: 412.660.7064
Fax: 724.249.2825

Positive Recovery Solutions Vivitrol Treatment Consent

I, _____ agree to treatment with Vivitrol. I understand that Vivitrol is an intramuscular injectable medication and needs to be given in the gluteal muscle. Positive Recovery Solutions LLC has explained the potential risks and side effects, including but not limited to pain at the injection site, unintended precipitation of opioid withdrawal, insomnia, nausea, vomiting, abdominal pain, dry mouth, local site reaction such as redness/rash and muscle cramps with more serious but rare occurrences including abscess formation at the injection site which may need further attention, serious allergic reaction, eosinophilic pneumonia, depression, and suicidality.

Vivitrol and Alcohol Dependence

I, _____ understand that although I am receiving Vivitrol for Alcohol/Opioid dependence I am still subject to consequences of alcohol impairment if I choose to consume alcohol with on Vivitrol. Consequences including but not limited to alcohol poisoning, slurred speech, drowsiness, distorted vision/hearing, cognitive function impairment, DUI, impaired gait and others are still applicable while receiving Vivitrol/Naltrexone. I have discussed any questions I may have and fully understand the use of Vivitrol for my alcohol/opioid dependence.

PRR Practices and Policies Regarding Discharge from Treatment

PRR strives to provide compassionate care for our patients. In the interest of ensuring that our patients receive appropriate care from PRR, there are guidelines that the patient must adhere to or be immediately discharged from treatment. Any threat or act of violence (including verbal) towards staff or other patients will be cause for immediately discharged. Any submission of urine specimen that is not your own or altered in any way is cause or immediate discharge. In the event the urine specimen is not the appropriate temperature at time of submission, the patient agrees to resubmit a specimen with the supervision of PRR Staff. If the patient refuses, PRR will consider the first specimen altered and the patient will be discharged immediately. **PRR CONSIDERS A PATIENT WHO HAD THREE POSITIVE URINE DRUG SCREENS DURING THEIR TREATMENT TO BE AN INAPPROPRIATE CANDIDATE FOR CONTINUED TREATMENT ON VIVITROL/NALTREXONE. PATIENT WILL BE CONSIDERED HIGH RISK FOR OVERDOSE/DEATH AND WILL BE REFERRED OUT TO ALTERNATIVE TREATMENT.** Discontinuing recommended Behavioral Health treatment as required by patient’s insurance coverage will be cause for discharge.

By signing this agreement, patient agrees that they understand the practices and policies regarding discharge from treatment as well as side effects and potential risks from the treatment of Vivitrol/Naltrexone. All questions have been asked and answered by the staff of Positive Recovery Solutions LLC.

Patient Signature: _____ Date: ____/____/____

PRR Staff Signature: _____ Date: ____/____/____



378 West Chestnut St. Suite 103
Washington PA, 15301
Office: 412.660.7064
Fax: 724.249.2825

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact:

*Positive Recovery Solutions
378 West Chestnut St.
Washington PA, 15301
412.660.7064*

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the healthcare and services you receive from PRS. Your health information may include information created and received by PRS, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatment, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment** – We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health. Different personnel in our organization may share information about you and disclose information to people who do not work for PRS in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.
- **For Payment** – We may use and disclose health information about you so that the treatment and services you receive at PRS may be billed to and payment may be collected from you, an insurance company or a third party



- **Required By Law** – We will disclose health information about you when required to do so by federal, state, or local law.
- **Public Health Risks** – We may disclose health information about you for public health reasons in order to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Lawsuits and Disputes** – If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement** – We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Information Not Personally Identifiable** – We may use or disclose health information about you in a way that does not personally identify you or reveal who you are
- **Family and Friends** – We may disclose health information about you to your family members or friends if we obtain your written agreement to do so. We may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment is discussed

OTHER USES AND DISCLOSURE OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*...

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy** – You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Positive Recovery Solutions LLC in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record. If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to Positive Recovery Solutions LLC. You have the right to request a copy of your health information in electronic form if we store your health information electronically.



- **Right to Amend** – If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Positive Recovery Solutions LLC
- **Right to Request Restrictions** – You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
- **Right to Request Confidential Communications** – You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- **Right to a Paper Copy of This Notice** – You have the right to a paper copy of this notice. We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our website or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services

ACKNOWLEDGEMENT

By signing I acknowledge that I have read and understand the information contained here within

Patient Name (Print): _____

Patient Signature: _____ Date: ____/____/____

PRRS Staff Signature: _____ Date: ____/____/____