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MS LEGACY - STEPPING STONES PSYCHIATRIC CARE : INSURANCE COMPANY

Welcome to MS Legacy - Stepping Stones Psychiatric Care (SSPC).

I (Print Name) _____ hearby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Insurance Company	
Name:	MS Legacy – SSPC	**Insurance:**	
Address:	Emerson Lane #1303	**ID # :**	
City/State/Zip:	Bridgeville PA 15017	**Group # :**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	
		Cardholder Name/DOB:	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

__ Admission & Intake Data __ Clinical Needs __ Continuing Care Recommendations __ Dates of Treatment __ Diagnosis
__ Discharge Plans __ Evaluation Summary __ Lab Reports __ Medication Management __ Progress Notes __ Psycho-Social
__ Telephone & Written Communication __ Treatment Plans

This protected health information is disclosed for the following purposes:
__ Referral to other services __ Coordination of Care __ Verbal Communication __ Transfer of Care __Consultation
__ Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.
_____I authorize the release or disclosure of this type of information. _____DO NOT RELEASE

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that SSPC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

This consent is valid between the following dates: _____ until _____.

I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT receiving a copy:

_____ _____ _____ _____
Patient Signature (if age 14 or older) Date Parent or Legal Guardian Signature Date

OR

_____ _____ _____ _____
Print Name of Witness or Staff Date Print Name & Relationship (if applicable) Date

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☐ An individual who cannot write has provided verbal consent, and two individuals have witnessed consent.