Hanlon Therapy Associates

INTAKE AND REFERRAL INFORMATION

Consumer's Name:_____DOB:____/___/___Age at referral: _____

Gender: Male / Female Servicing County:_____Referral Date:_____/_____/_____

Date services first requested:_____/_____/_____ Start date of services:_____/_____/_____

Services Requested: _____BSS _____CS _____SSB _____SE _____other (specify)

Referring Agency:_____Contact & phone:_____

MA#:_____SSN: _____

Consumer's Address & County: _____ _____ Phone: _____ Consumer resides with: _____	Current Medications: _____ _____ _____ _____
Parent / Guardian Names: _____ _____ Address / Phone (if different than consumer's): _____ _____	Name of School or Employer: See Page 2 for additional space _____ Phone #:_____ School/Employer contact person:_____ _____ Title of contact:_____
Diagnosis: Axis I: _____ _____ _____ _____ Axis II: _____ Axis III:_____ Axis IV: _____ _____ _____ Axis V: _____	Primary Care Physician: _____ Phone:_____ Insurance Company:_____ Group #: _____ Policy #: _____ Other agencies / information:_____ _____ _____ _____ _____

Consumer/Legal Guardian Signature:_____Date:_____

Additional Medications and School/Employer Information

Current Medications: _____

_____

_____

_____ _____

_____

Name of School or Employer:_____Phone:_____

School/Employer contact person:_____

Title of contact:_____

Name of School or Employer:_____Phone:_____

School/Employer contact person:_____

Title of contact:_____

I hereby give consent that all program staff may observe me/my child take his/her prescribed medications.

Consumer/Legal Guardian Signature:_____Date_____

Hanlon Therapy Associates

EMERGENCY INFORMATION SHEET

Consumer's Name: _____ **DOB:**_____/_____/_____ **Age:**_____

Address:_____

Parent / Legal Guardian (s) **Telephone**

_____ **Home:**_____**Work:**_____

_____ **Home:**_____**Work:**_____

In case of emergency please contact

_____ **Home:**_____**Work:**_____

_____ **Home:**_____**Work:**_____

_____ **Home:**_____**Work:**_____

Home:_____**Work:**_____

MEDICAL INFORMATION

Name of Consumer's Physician: _____

Address:_____

Telephone:_____

Known Allergies: _____

REQUIRED MEDICATION

Name of Medication	Dosage	Time

Special Diet Considerations: None

Allergic to bee stings? _____Yes X No

Other important information you would like us to know: _____

_____

I hereby give consent that all program staff may observe me/my child take his/her prescribed medications.

Consumer/Legal Guardian Signature:_____**Date**_____

Additional Medicine Information

Name of Medication	Dosage	Time	Prescribing Physician	Phone Number

Consumer/Legal Guardian Signature:_____Date: _____

Hanlon Therapy Associates

CONSENT TO TREATMENT
AND TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I _____, understand and agree that Hanlon Therapy Associates, LLC. may provide treatment services and use and disclose my protected health information for purposes of my treatment, an for payment and healthcare operations on my behalf. The protected health information that Hanlon Therapy Associates, LLC. will be compiling includes but is not limited to: my name; address; personally identifying information such as my social security number, phone numbers and emergency contacts; symptoms health history; diagnoses; treatment history including future treatment recommendations; examination and test results; and medications. I understand that I must consent to the use and disclosure of my protected health information in order to enroll in and receive treatment services through Hanlon Therapy Associates, LLC.

I understand that I have the right to revoke my consent, in writing or by having my oral revocation documented in writing for me, at any time, except to the extent that Hanlon Therapy Associates has provided services relying on my consent.

I further acknowledge that I have been provided with a copy of the Hanlon Therapy Associates, LLC. Privacy Notice and have been given the opportunity to read and discuss it before signing this Consent Form. I understand that Hanlon Therapy Associates has the right to revise its Privacy Notice from time to time as needed, and that copies of the revised Privacy Notice will be made available to me at the treatment program site. I also understand, as outlined in the Hanlon Therapy Associates, LLC. Privacy Notice, that: (1) I have the right to request restrictions on how my protected health information is used or disclosed to carry out the treatment, payment, or healthcare operations performed on my behalf; (2) Hanlon Therapy Associates, LLC. is not required by law to agree to my requested restrictions; and (3Hanlon Therapy Associates, LLC. agrees to a requested restriction it will be) documented file and be binding on any use or disclosure of my protected health information by Hanlon Therapy Associates, LLC. I have reviewed this Consent Form and understand that my signature and the date of signing the Consent Form must be completed and witnessed so that my consent is valid and binding.

Consumer/Legal Guardian Signature:_____ **Date:** _____

HTA Staff Witness Signature: _____ **Date:** _____

Hanlon Therapy Associates

COMPLAINT / GRIEVANCE PROCEDURE

You have the right to file a complaint / grievance regarding the nature or quality of the service provided to you by Hanlon Therapy Associates, LLC. Your complaint / grievance may by in writing, addressed to:

Hanlon Therapy Associates

ATTN: Mike Hanlon

3011 Sir Charles Dr.

MacDonald, PA. 15057

Mike Hanlon can be contacted by email at Mike@hanlontherapy.com or by phone at: 724-492-1122

When calling, please state that you wish to file a complaint / grievance. Please include your full name, address, telephone number, and the nature of your complaint / grievance. Staff will transcribe a brief written statement dictated by you which then will be logged and a copy given to you.

A Hanlon Therapy Associates staff person assigned to help resolve your complaint / grievance will contact you within 48 hours. You have the right to be assisted by an advocate of your choice in resolving your complaint / grievance.

You may contact either your insurance company or county officials any time during the complaint / grievance process.

Hanlon Therapy Associates

ACKNOWLEDGEMENT FORM
FOR RECEIPT OF POLICIES AND PROCEDURES

Consumer's Name: _____ DOB:_____/____/____ Age:_____

COMPLAINT / GRIEVANCE PROCEDURE

I acknowledge that I have received a copy of the Hanlon Therapy Associates Complaint / Grievance Policy and Procedure. I understand that if I have any questions in regards to the procedure, I should contact my local office for clarification.

Consumer/Legal Guardian Signature:_____Date:_____

HTA Staff Witness Signature: _____Date:_____

HIPPA

I acknowledge that I have received a copy of the Health Insurance Privacy Practices (HIPPA) and the Hanlon Therapy Associates notice for the use and disclosure of protected health information for treatment, payment, and healthcare operations.

Consumer/Legal Guardian Signature:_____Date:_____

HTA Staff Witness Signature: _____Date:_____

Hanlon Therapy Associates

What is this Notice for?

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

What DO We Do To Keep Your Health Information Private?

Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. You have the right to discuss your concerns about how your health information is shared. The law under the Health Insurance Portability and Accountability Act (HIPAA) says:

1. **We must keep your health information from others who do not need to know it.**
2. **We must make this Notice available to you, and may only use and share your health information**

as explained in this Notice.

Who May Use And See My Health Information?

Hanlon Therapy Associates (HTA) employees, such as program administrators, may use or share your health information for treatment, payment, and healthcare operations.

Treatment: We may use or share your health information for treatment. For example, we may use health information we receive from another health care provider who has seen you, to ensure that you are referred for further needed treatment.

Payment: We may use or share your health information in order to ensure that health services you have received through our programs are paid for. For example, we may exchange information about you with another government agency, or a health care provider who has provided you with health services.

Healthcare Operations: We may use and share your health information in order to manage our programs and to make sure that they serve you well. For example, we may review your health information and share it with other Commonwealth agencies that must also keep your health information private.

What If HTA Wants To Use Or Share My Health Information For Other Reasons?

You will be asked to sign a separate form, called an authorization form, allowing your health information to be used or shared other than for treatment, payment or business operations. The authorization form limits what health information may be used or sent, and says where and to whom the information may be sent. You can cancel the authorization at any time by letting us know in writing.

Your written authorization is required for the use and disclosure of:

1. Psychotherapy notes (with limited exceptions to include certain treatment, payment or healthcare operations).
2. Marketing purposes (with limited exceptions).
3. Disclosure in exchange for remuneration on behalf of the recipient of your protected health information.

What Rights Do I Have With Regard To My Health Information

You have the following rights with respect to your health information:

1. To amend your information. If you think some of your health information is incorrect or incomplete, you may ask that corrected or new information be added by making a request in writing to the HTA Office. You must state why you think the correction or new information is necessary. We do not have to make the requested amendment. If we do, you may ask that the corrected or new information be sent to others who have received your health information from us. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

2. To tell us that you want your health information to be sent somewhere else. We will again ask you to sign an authorization form. You may be charged for the cost of the copies and sending them. If we have HIV or substance abuse information about you, we cannot release it without a special signed, written authorization from you that complies with the laws governing HIV or substance abuse records. Certain other laws that we must comply with may require us to follow the special requirements of those laws in addition to HIPAA.

3. To inspect and copy certain health information. To inspect and copy your protected health information, you must submit your request in writing to HTA. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. You may not see the private notes taken by a mental health provider, health information compiled as part of a legal case, or in other limited circumstances. In some cases, if we deny your request to see your health information, you may request a review of the denial.

4. To get a list of where we shared your health information for the last 6 years, unless it was shared for treatment, payment, or healthcare operations. If you ask for more than one list a year, you may be charged for the cost of providing the list. Your request for your health information must be made in writing to HTA.

5. To request that HTA communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or phone, or at an address or phone number other than at your home.
6. To request a restriction or limitation on your health information that we use or disclose for treatment, payment, or health care operations. You also can request a limit on your health information that we disclose to someone who is involved in your care such as a family member or friend. We do not have to

agree to the restriction or limitations. If we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions make a request to the HIPAA Contact Office, you must make your request in writing and tell us what information you want to limit. **7.** To be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Could My Health Information Be Used Or Released Without My Authorization?

We follow laws that tell us when we have to share health information, even if you do not sign an authorization form. We will use or release your health information:

1. For public health reasons, including to prevent or control disease or injury; or report births or deaths, suspected abuse or neglect, reactions to medications or problems with certain health-related products.

2. **To prevent serious threats to your health or safety or that of another person or the public.**
3. **To carry out treatment, payment or healthcare operations.**
4. **To carry out administrative functions your information may be released to specific employees who**

assist in the administration of the benefits.
5. To help health oversight agencies monitor the health care system, government programs, and compliance with civil rights laws, including for audits, investigations, inspections, or licensing purposes.

6. If a court orders us to, or if we receive a subpoena and receive certain assurances from the person seeking the information.
7. To law enforcement officials, if we receive a proper request and the request meets all other legal requirements.

8. To coroners, medical examiners or funeral directors, in order to help identify a deceased person, determine the cause of death, or perform other legally authorized duties.

9. **To organ procurement organizations, if you are an organ donor or as legally required.**
10. **For health-related research that meets applicable legal requirements.**
11. **To military authorities, if you were or are a member of the armed forces and the request is made**

by appropriate military command authorities.
12. To authorized federal officials for national security purposes. **13.** To Workers Compensation for work-related injuries.

14. To other government benefit programs in order to coordinate or improve administration and management of the programs.
15. To family or others involved in your treatment or financial affairs, if you have indicated that we can do so or if we can reasonably infer that you do not object.

16. As otherwise required by law.

When Is This Notice Effective?

This Notice went into effect on May, 2017.

May I Have A Copy Of This Notice?

You have a right to a paper copy of this Notice of Privacy Practice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. We reserve the right to change this Notice, and to apply the new practices to all of your health information, including information we received before the Notice was changed. If we change this Notice and you are still in our Program, we will send you a new one upon request. You are entitled to the most current copy of the Notice. You can find the most current notice at **http://www.health.state.pa.us/hipaa**

Contact Information for Complaints or Questions

If you have questions or feel your privacy rights have been violated, you can ask questions or complain by writing to or calling the **HTA Office- 3011 Sir Charles Dr. MacDonald, Pa. 15057 . 724-492-1122.**

You can also complain to the federal government, Secretary of Health and Human Services, by writing to: U.S. Department of Health & Human Services, Office for Civil Rights, 150 S. Independence Mall West - Suite 372, Philadelphia, PA. 19106-3499.

Will It Make Trouble for Me If I Complain?

Your services will not be affected by any complaint made to the HTA Privacy Officer

Consumer/ Legal Guardian Signature: Date:

Witness Signature: Date:

EXERCISE OF RIGHTS

Exercise of Rights

(a) An individual may not be deprived of rights.
(b) Each individual shall be continually supported to exercise the individual's rights.
(c) Each individual shall be provided the support and accommodation necessary to be able to understand and actively exercise his/her rights.
(d) An individual may not be reprimanded, punished, or retaliated against for exercising his/her rights.
(e) A court's written order that restricts an individual's rights shall be followed.
(f) A court-appointed legal guardian may exercise rights on behalf of an individual, in accordance with a courtorder.
(g) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights. shall be involved in decision-making to the extent practical and appropriate.
(h) An individual has the right to designate persons to assist in decision-making on behalf of the individual.

Rights of the Individual

(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, sexual orientation, national origin or age.
(b) An individual has the right to civil and legal rights afford by statute to include the right to vote, speak freely, sexual expression and practice the religion of his/her choice or to practice no religion.
(c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.
(d) An individual shall be treated with dignity and respect.
(e) An individual has the right to make choices and accept risks.
(f) An individual has the right to refuse to participate in activities and supports.
(g) An individual has the right to control his/her own schedule.
(h) An individual has the right to privacy of person and possessions.
(i) An individual has the right to choose a willing and qualified provider.
(j) An individual has the right to choose where, when and how to receive needed supports.
(k) An individual has the right to voice concerns about the supports the individual receives.
(l) An individual has the right to participate in the development and implementation of the person-centered support plan.
(m) An individual has the right to access to, and security of, his/her possessions.

Negotiation of Choices

An individual rights shall be exercised so that another individual's rights are not violated. Choices shall be negotiated by affected individuals, in accordance with the provider's procedures for the individuals to resolve differences and make choices.

Informing of Rights

(a) The provider shall inform and explain individual rights to the individual, and persons designated by the individual, upon entry into the program and annually thereafter.

(b) Statements signed by the individual, or an individuals' court-appointed legal guardian, acknowledging receipt of the information on individual rights shall be kept.

Role of Family and Friends

(a) A provider shall not discourage an individual from visits with family and friends.

(b) A provider shall not discourage the participation of the individual's family and friends in decision-making, planning and other activities.

(c) A provider shall facilitate and make the accommodations necessary to involve the individual's family and friends in planning, decision-making and other activities, at the discretion of the individual.

Consumer/ Legal Guardian Signature: **Date:**

_____ _____

Witness Signature: **Date:**

_____ _____

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates to:

Obtain from:

_____

_____

_____

Phone Number: _____

Release to:

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X Psychological Evaluation
X Social History
X Psychiatric Evaluation
X Oral and/or written communications in order to provide therapeutic services and coordinate care
____ Other: (specify)_____

X Treatment Discharge Summary
X Neurological Evaluation
X Independent Educational Plan

X Past Psychiatric History
X Treatment Plan
X Services Rendered Form

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. ■ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____

Signature of person if 14 years of age or older | Date | Signature legal guardian/personal representative | Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from: Primary Care Physician

_____

_____

_____

Phone Number: _____

Release to: Primary Care Physician

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X Psychological Evaluation
X Social History
X Psychiatric Evaluation
X Oral and/or written communications in order to provide therapeutic services and coordinate care
X Treatment Discharge Summary
X Neurological Evaluation
X Independent Educational Plan
X Past Psychiatric History
X Treatment Plan
X Services Rendered Form
____ Other: (specify)_____

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. ■ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____

Signature of person if 14 years of age or older | Date | Signature legal guardian/personal representative | Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from: Bureau of Autism Services

_____

_____

_____

Phone Number: _____

Release to: Bureau of Autism Services

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X Psychological Evaluation
X Social History
X Psychiatric Evaluation
X Oral and/or written communications in order to provide therapeutic services and coordinate care
X Treatment Discharge Summary
X Neurological Evaluation
X Independent Educational Plan
X Past Psychiatric History
X Treatment Plan
X Services Rendered Form
____ Other: (specify)_____

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. ■ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____

Signature of person if 14 years of age or older | Date | Signature legal guardian/personal representative | Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from: Other BAS Waiver Provider

_____

_____

_____

Phone Number: _____

Release to: Other BAS Waiver Provider

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X Psychological Evaluation
X Social History
X Psychiatric Evaluation
X Oral and/or written communications in order to provide therapeutic services and coordinate care
X Treatment Discharge Summary
X Neurological Evaluation
X Independent Educational Plan
X Past Psychiatric History
X Treatment Plan
X Services Rendered Form
____ Other: (specify)_____

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. ■ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____

Signature of person if 14 years of age or older | Date | Signature legal guardian/personal representative | Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from: Parent/Legal Guardian

_____

_____

_____

Phone Number: _____

Release to: Parent/ Legal Guardian

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X___ Psychological Evaluation X___ Treatment Discharge Summary X___ Past Psychiatric History
X___ Social History X___ Neurological Evaluation X___ Treatment Plan
X___ Psychiatric Evaluation X___ Independent Educational Plan X___ Services Rendered Form
X___ Oral and/or written communications in order to provide therapeutic services and coordinate care
____ Other: (specify)_____

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the HTA, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. ■ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____
Signature of person if 14 years of age or older Date Signature legal guardian/personal representative Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from: Psychiatrist

_____

_____

_____

Phone Number: _____

Release to: Psychiatrist

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X Psychological Evaluation
X Social History
X Psychiatric Evaluation
X Oral and/or written communications in order to provide therapeutic services and coordinate care
____ Other: (specify)_____

X Treatment Discharge Summary
X Neurological Evaluation
X Independent Educational Plan

X Past Psychiatric History
X Treatment Plan
X Services Rendered Form

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. □ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____

Signature of person if 14 years of age or older | Date | Signature legal guardian/personal representative | Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from: Employer

_____

_____

_____

Phone Number: _____

Release to: Employer

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X Psychological Evaluation
X Social History
X Psychiatric Evaluation
X Oral and/or written communications in order to provide therapeutic services and coordinate care
X Treatment Discharge Summary
X Neurological Evaluation
X Independent Educational Plan
X Past Psychiatric History
X Treatment Plan
X Services Rendered Form
____ Other: (specify)_____

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. □ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____

Signature of person if 14 years of age or older | Date | Signature legal guardian/personal representative | Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from: supports coordination group

_____

_____

_____

Phone Number: _____

Release to: supports coordination group

_____

_____

_____

Phone Number:_____

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

X Psychological Evaluation
X Social History
X Psychiatric Evaluation
X Oral and/or written communications in order to provide therapeutic services and coordinate care
X Treatment Discharge Summary
X Neurological Evaluation
X Independent Educational Plan
X Past Psychiatric History
X Treatment Plan
X Services Rendered Form
____ Other: (specify)_____

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. ■ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____

Signature of person if 14 years of age or older | Date | Signature legal guardian/personal representative | Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

PROHIBITION ON REDISCLOSURE: Confidential health care information has been disclosed to you from records whose confidentiality is protected by State and Federal law. Federal and State laws prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hanlon Therapy Associates

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Consumer Name: _____ Date of Birth: _____

MA Number: _____

I hereby authorize Hanlon Therapy Associates, Inc. to:

Obtain from:
_____

_____

Phone Number: _____

Release to: Department of Public Welfare
Provider Billing/Claims Portal

Phone Number: 1-866-386-8880

Please specify the following information (must be specific to type and time frame of requested information):

The following information:

____ Psychological Evaluation ____ Treatment Discharge Summary _____ Past Psychiatric History
____ Social History ____ Neurological Evaluation _____ Treatment Plan
____ Psychiatric Evaluation ____ Independent Educational Plan _____ Services Rendered Form
____ Oral and/or written communications in order to provide therapeutic services and coordinate care
X Other: submitting and correcting claims/claim issues for billing purposes only. No clinical information will be shared.

I authorize the request for or release of this information for the following purpose:
Coordination of services for the above named consumer

I understand that the confidentiality of the above records and information is protected by Federal and State laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be released without my written authorization except under special circumstances as provided by the same laws and regulations.

I also understand that my authorization is valid for no more than one (1) year from the date signed and that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) verbally or in writing to the Director of the Hanlon Therapy Associates, Inc program from which I am receiving or have received treatment.

I acknowledge that I have been offered a copy of the Authorization to Release Information form. ■ Yes □ No

Date Authorization Given: _____ Date Authorization Expires: _____

_____ _____ _____ _____
Signature of person if 14 years of age or older Date Signature legal guardian/personal representative Date

Relationship to Client: ■ Self □ Personal Representative/Parent □ Legal Guardian

Signature of HTA Staff/ Witness: _____ Date: _____

The signature of a second witness is required only if the person is physically unable to sign but has given verbal consent.

Second Witness (if applicable): _____ Date: _____

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