JOHN G. KUNA, PSYD & ASSOCIATES

570.961.3361 DRJOHNGKUNA.COM 570.961.3364 (F)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize John G. Kuna, PsyD & Associates to release information from the record of

Patient Name: _____ **Date of Birth**: _____ as described below to

Facility/Person to receive records: _____

_____

Street City Zip Code

Phone: _____ Fax: _____

Disclosed Information *(check all items to be released)*

- ☐ Psychiatric Evaluation
- ☐ Psychological/Achievement Tests
- ☐ Medical History
- ☐ Developmental History
- ☐ Social History
- ☐ Academic/School reports
- ☐ Discharge Summary
- ☐ Summary of Hospitalizations
- ☐ Course of Treatment
- ☐ Treatment Recommendations
- ☐ Other (please specify) _____

AIDS/HIV Information
☐ Yes, disclose
☐ No, do not disclose

Psychiatric Care
☐ Yes, disclose
☐ No, do not disclose

Treatment for Drug/Alcohol Abuse
☐ Yes, disclose
☐ No, do not disclose

Authorization Expires *(insert date or event)* ☐ 1 year from date of authorization
☐ Other Date or Event (please specify): From: _____ to _____

Purpose/Use Of The Requested Information
☐ Sharing with health care providers ☐ Personal Use ☐ Social Security ☐ Legal/Litigation
☐ Worker's compensation ☐ Other (please describe) _____

ASSOCIATES
Sylvie Acoulon, LCSW
Karlene Albrecht, LPC
Patricia Arcaro-Krenitsky, LPC
Jennifer Buckwash, LPC
Anthony Black, LCSW
Mary-Ann Chupella, LCSW
Jeanne Decker, LCSW
Joanna Delio, LCSW
Marcy Duffy, LPC, CAADC
David Falbo, LPC
Dr. John Gibbons, LCSW
Nadine Gowarty, PsyD, LPC
Tammy Gregorowicz, PhD
Sara Grier, LCSW
Joanne Judge, LSW
Alexis KELLY, LCSW
Lori Kishel, LSW
Kristin Levandoski, LPC
Jennifer Marzzacco, LSW
Michele McDermott, LCSW
Shannon McLafferty, LSW
Cortney O'Malley, LSW
Michele Pizzutti-Elliott, LPC
Keith Ripley, LPC, CADC
Whitney Robenbolt, PsyD
Theresa Schirg, LCSW
Linda Strain, LPC
Maggie Snyder, LCSW
Traci Thomas, LCSW
Jodi Weiskerger, LSW
Bethany Woznikaitis, LCSW
Philip Zuckerman, LCSW

Authorization

X _____ _____
Signature of Patient (or Personal Representative) Date

Print name: _____

X _____ _____
Signature of staff person obtaining the consent (required for mental health records) Date

I have been informed that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for 90 days after the date of my signature, unless otherwise specified below. I also understand that this consent is revocable, by contacting JGKA in writing, except to the extent that action has been taken in reliance thereon. We will not condition treatment, payment, or enrollment in services on the person providing authorization for the requested use or disclosure.

Verbal Consent *(If the patient is physically unable to provide a signature. A verbal consent may be revoked by a verbal statement verified in writing by two witnesses.)* I witness that the patient was physically unable to provide a signature, but that he/she understood the nature of this release and freely gave his/her oral authorization.

Witness: _____ Witness Printed Name: _____ Date: _____

Witness Signature: _____ Witness Printed Name: _____ Date: _____