Family Guidance Center

EMPOWERING PEOPLE TO IMPROVE THE QUALITY OF THEIR PERSONAL AND PROFESSIONAL LIVES

1105 Berkshire Boulevard, Suite 110, Wyomissing, PA 19610 • 610.374.4963 • 610.378.5403 Fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

A. CLIENT INFORMATION	CHART#

CLIENT NAME:_____ DATE OF BIRTH:_____

CLIENT ADDRESS:_____

TELEPHONE CONTACT:_____

B. I AUTHORIZE FAMILY GUIDANCE CENTER TO…	☐ RELEASE TO:	☐ RECEIVE FROM:

NAME:_____

ADDRESS:_____

PHONE:_____ FAX: _____

C. INFORMATION TO BE RELEASED	
☐Complete Medical Record ☐ Medication History ☐Clinical Note(s) ☐ Presence in Service ☐Diagnosis ☐ Psychosocial Evaluation ☐Discharge Summary ☐ Psychiatric Evaluation ☐Medication Check Visits ☐ Treatment Plans ☐Other/Dates to be released:_____	PURPOSE: ☐Coordinate Care ☐ Personal* ☐Insurance* ☐ School ☐Legal Matter* ☐ Disability* ☐Other* _____ *Copying fees may apply(PA law, 42Pa.C.S. 6152)

D. I UNDERSTAND:	
• If included in the medical record, this authorization includes the release of information protected by: Confidentially of HIV-Related Information Act (AIDS, HIV-related information or testing, Drug and Alcohol Treatment information in accordance with 4PA code subsection 255.5(b)), unless otherwise indicated☐DO NOT RELEASE • The nature of the information to be released or obtained. • Any information I authorize other facilities or professionals to release/obtain will be held strictly confidential and will not be further disclosed without my permission. • I may revoke my authorization (except to the extent that action has already been taken) at any time by sending a letter or verbally notifying the Privacy Officer or my counselor. • This authorization to release/obtain confidential information will remain valid for up to 365 days from the date of this form. • I have the right to inspect or copy the health information to be used or disclosed as permitted by law.	_____ CLIENT SIGNATURE (14 yrs of age or older) **DATE** _____ CLIENT PRINTED NAME _____ PARENT/GUARDIAN for client under 14 yrs of age **DATE** _____ SIGNATURE OF WITNESS **DATE**

E. ORAL CONSENT	
For Persons Physically Unable to Provide a Signature. I Witness that the person understood the nature of this release and freely gave his/her oral consent (**two witnesses required**)	_____ Signature of Witness Date _____ Signature of Witness Date

Original 9/06; 6/07; 10/09; 3/15; 5/18; 1/23; 10/24