Family Guidance Center

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

1235 Penn Avenue, Suites 205-206, 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 MY PHI TO BE:

RELEASED BY:	RELEASED TO:
NAME:_____	NAME:_____
ADDRESS:_____	ADDRESS:_____
_____	_____
PHONE:_____FAX: _____	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 OF SERVICE:

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.
- 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'S SIGNATURE (14 yrs of age or older) DATE

_____
CLIENT'S PRINTED NAME

_____
PARENT/GUARDIAN for client's 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