

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

A. CLIENT INFORMATION  CLIENT NAME:  DATE OF BIRTH:  DATE OF BIRTH:  DATE OF BIRTH:  B. I AUTHORIZE MY PHI TO BE:  RELEASED BY:  NAME:  ADDRESS:  PHONE:  FAX:  DATES OF SERVICE:  PURPOSE:  Complete Medical Record   Medication History  Colinical Note(s)   Presence in Service  Diagnosis   Psychosocial Evaluation  Dibscharge Summary   Psychiatric Evaluation  Dimedication Check Visits   Treatment Plans  Other  For Person of information protected by: Confidentially of HIV-Related Information in accordance with 4PA code subsection 255.5(b), unless otherwise indicated IDO 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.  This authorization to release/obtain confidential information will remain valid for up to 365 days from the date of this form.  To Persons Physically Unable to Provide a Signature.  PARENT/GUARDIAN for cliem's under 14 yrs of age DATE  SIGNATURE OF WITNESS  DATE	AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)	
CLIENT ADDRESS:  TELEPHONE CONTACT:  B. I AUTHORIZE MY PHI TO BE:  RELEASED BY:  NAME:  ADDRESS:  PHONE:  FAX:  C. INFORMATION TO BE RELEASED  DATES OF SERVICE:  DOUBLE Medical Record   Medication History   Personce in Service   Coordinate Care   Personal*   Disability*   Disabilit		. , ,
B. I AUTHORIZE MY PHI TO BE:  RELEASED BY:  NAMF:  ADDRESS:  PHONE:  FAX:  PHONE:  FAX:  PHONE:  PHONE:  FAX:  PHONE:		DATE OF BIRTH:
B. LAUTHORIZE MY PHI TO BE:  RELEASED BY:  NAME:  ADDRESS:  ADDRESS:  PHONE:  FAX:  PHONE:  FAX:  PHONE:  PHONE:  FAX:  PHONE:  PHONE:	CLIENT ADDRESS:	
RELEASED BY:  NAME:  ADDRESS:  PHONE: FAX: PHONE: FAX:  DATES OF SERVICE:  CINFORMATION TO BE RELEASED  Omplete Medical Record Medication History Clinical Note(s) Presence in Service Diagnosis Psychosocial Evaluation Discharge Summary Psychiatric Evaluation Medication Check Visits Treatment Plans Oother  Other*  To J. IUNDERSTAND:  If included in the medical record, this authorization includes the release of information protected by: Confidentially of HIV-Related information 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.  In any revoke my authorization 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.  I have the right to inspect or copy the health information to be used or disclosed as permitted by law.  For Persons Physically Unable to Provide a Signature.  I Winess that the person undersood the nature of this release and freely gave his/her oral consent (two witnesses)  Signature of Witness  Date	TELEPHONE CONTACT:	
NAME: ADDRESS: ADDRESS: PHONE: FAX: PHONE: FAX:  DATES OF SERVICE: C. INFORMATION TO BE RELEASED OCOmplete Medical Record   Medication History   Clinical Note(s)   Presence in Service   Diagnosis   Psychosocial Evaluation   Discharge Summary   Psychiatric Evaluation   Discharge Summary   Psychiatric Evaluation   Legal Matter*   Disability*     Other   DI Himedical record, this authorization includes the release of information protected by: Confidentially of HIV-Related Information Act (AIDS, HIV-related 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. I have the right to inspect or copy the health information to be used or disclosed as permitted by law. I have the right to inspect or copy the health information to be used or disclosed as permitted by law. I witness that the person understood the nature of this release and freely gave his/her oral consent (two witnesses  NAME:  ADDRESS:  PHONE: FAX:  PARENT/GOSE   Ccordinate Care   Personal*   Personal*   Disability*   Dottor* **Copying fees may apply(PA law, 42Pa.C.S. 6152)  CLIENT'S SIGNATURE (14 yrs of age or older)  CLIENT'S PRINTED NAME  CLIENT'S PRINTED NAME  PARENT/GUARDIAN for client's under 14 yrs of age DATE  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)  Signature of Witness  Signature of Witness	B. I AUTHORIZE MY PHI TO BE:	
ADDRESS:	RELEASED BY:	RELEASED TO:
PHONE: FAX: PHONE: FAX:  C. INFORMATION TO BE RELEASED    Complete Medical Record   Medication History   PURPOSE:   Coordinate Care   Personal*   Coordinate Care   Personal*   Disagnosis   Psychosocial Evaluation   Discharge Summary   Psychiatric Evaluation   Dotter   Porsonal*   Disability*   Dotter   Porsonal*   Disability*   Dotter   Porsonal*   Disability*   Dotter   Porsonal*   Disability*   Disability*   Dotter   Porsonal*   Disability*   Disability*   Dotter   Porsonal*   Disability*   Disability*   Disability*   Dotter   Disability*   Disability*   Dotter   Porsonal*   Disability*   D	NAME:	NAME:
DATE OF SERVICE:	ADDRESS:	
DATES OF SERVICE:		
Complete Medical Record   Medication History   Coordinate Care   Coordinate Care   Service   Coordinate Care   Coordinate Care   Service   Coordinate Care   Coordinate   Coordina	PHONE:FAX:	PHONE:FAX:
Complete Medical Record   Medication History   Coordinate Care   Coordinate Care   Service   Coordinate Care   Coordinate Care   Service   Coordinate Care   Coordinate   Coordina	C. INFORMATION TO BE RELEASED	DATES OF SERVICE:
Clinical Note(s)		
Diagnosis	•	☐ Coordinate Care ☐ Personal*
Discharge Summary		□Insurance* □ School
Other  Other  Other  Other  Notice of the medication Check Visits □ Treatment Plans □ Other  Notice of the medication Check Visits □ Treatment Plans □ Other  **Copying fees may apply(PA law, 42Pa.C.S. 6152)  Other  **Copying fees may apply(PA law, 42Pa.C.S. 6152)  I 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.  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  Oother*  **Copying fees may apply(PA law, 42Pa.C.S. 6152)  **Copying fees may apply(PA law, 42Pa.C.S. 6152)  **Copying fees may apply(PA law, 42Pa.C.S. 6152)  **CLIENT'S SIGNATURE (14 yrs of age or older)  DATE  **CLIENT'S PRINTED NAME  CLIENT'S PRINTED NAME  **CLIENT'S PRINTED NAME  **CIENT'S PRINTED NAME  **CLIENT'S PRINTED NAME  **CIENT'S PRINTED NAME  **CIENT'S PRINTED NAME  **CI		
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and freely gave his/her oral consent ( <b>two witnesses</b> Signature of Witness Date		
		Cinnature of Witness
	· -	Signature of witness Date

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



Signature of Witness

Date