Pennsylvania Counseling Services, Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient ID: _____ External Patient ID: _____

Patient Name: _____ Patient DOB: _____

I, _____ do hereby consent to authorize **Pennsylvania Counseling Services** to disclose to _____ information from my record(s). The specific information to be disclosed includes:

☑ Admission ☐ Summary of Treatment ☐ Treatment Plans/Aftercare Plans ☐ Medical History
☐ Attendance in Treatment ☐ Substance Screen Results ☐ Patient Data Form ☐ Initial Evaluation
☐ Progress in Treatment ☐ Medication Management Notes ☐ Prescription Information ☐ Progress Notes
☐ Prognosis/Diagnosis/ Treatment Recommendations ☐ Discharge Summary ☐ Psychiatric/Psychological Evaluation

☐ Other _____

I, _____ do hereby consent to authorize **Pennsylvania Counseling Services** to receive from _____ information from my record(s). The specific information to be received includes:

☑ Admission ☐ Summary of Treatment ☐ Treatment Plans/Aftercare Plans ☐ Evaluations/Assessments
☐ Attendance in Treatment ☐ Substance Screen Results ☐ Patient Data Form ☐ Initial Evaluation
☐ Progress in Treatment ☐ Medication Management Notes ☐ Social History ☐ Medical History and Physical
☐ Prognosis/Diagnosis/ Treatment Recommendations ☐ Discharge Summary ☐ Psychiatric/Psychological Evaluation ☐ Prescription Information
☐ Progress Notes

☐ Other _____

I understand that the information is to be used for the purpose of _____

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Law 93-282, and/or Code of Federal Regulations, 42 (Drug and Alcohol treatment records). I understand that I have the right to request to inspect materials that shall be released. I understand that I may revoke this authorization at any time by notifying facility staff verbally or in writing. This authorization shall expire six (6) months after discharge unless an earlier date is specified.

If the patient is not in treatment at the time of signing, this authorization will expire three (3) months after signing.

Authorization was REVOKED on _____ (DATE) at _____ (TIME)

Facility Staff Signature _____

Mental Health: Patients age 14 or older must sign. Patients under age 14, Parent/Guardian/POA must sign.
Drug and Alcohol: Patient must sign regardless of age.

⊗ _____ _____

Signature ☐ Patient ☐ Parent ☐ Guardian ☐ Power of Attorney Date

_____ _____

Signature of Staff Obtaining Consent Date

Patient has ☐ accepted ☐ rejected a copy of this document.

INSTRUCTIONS ON FULLY COMPLETING PCS RELEASE:

TOP SECTION: This section must be completed if an alleged client wishes for their confidential information to be DISCLOSED to a third party:

1. Alleged Client's name (only one name per form) must be filled in and legible in the space after "I, _____, do hereby…."
2. The name of the person or entity that records are to be released to must be legibly written (no abbreviations) in the space after "…to disclose to …"
3. ONLY items that have a check mark or "X" beside them may be released. If nothing is checked or marked, nothing may be released. **Please note that most clinical documents contain the information of the first four items in the first column and without those marked, most other records (i.e. Progress notes, discharge summary, initial evaluation, etc.) will not be able to be released in their entirety or possibly, not at all.**
4. For items not listed (i.e. billing records, special reports or forms, …) "other" must be checked or marked and the information being requested must be clearly stated.
5. A purpose MUST be completed in the lined space after "I understand that this information is to be used for the purpose of _____." (Common purposes are: continuity of care, securing disability benefits, legal representation…) Again, no abbreviations.
6. Alleged Client (age 14 or older for mental health treatment, or any age for drug and alcohol treatment) must sign and mark the patient box.
7. For mental health, if alleged client is under the age of 14, parent or legal guardian must sign and mark appropriate box (parent or guardian). Full name must be signed (ex. Not just first name with last initial).
8. A check mark or X must be placed in the box next to the appropriate title of person signing the release (patient, parent, guardian, or power of attorney).
9. If power of attorney is signing, then a copy of the power of attorney document must be in the alleged client's file.
10. Alleged Client's date of birth (near the top of the form) must be completed.
11. At the very bottom of the form, check mark whether the alleged client has accepted or refused a copy of the release.

SECOND AUTHORIZATION SECTION ('TO RECEIVE FROM'): This section must be completed only if an alleged client wishes for PCS to RECEIVE information from a third party. Otherwise, please leave this section blank.

BOTTOM BOX:
This box is where we record if/when a client chooses to revoke a release. Any marks inside this box will void the release.