

## AUTHORIZATION FOR RELEASE OF INFORMATION

**My signature as listed below, confirms my voluntary participation in a Pennsylvania Counseling Services, Inc. Warrior Project (Transitional Support Adolescents). I understand that the Warrior Project is not treatment, but is a program that utilizes person centered planning to create a plan that will assist with preparing for adulthood and incorporating formal and informal supports.**

I, \_\_\_\_\_,

do hereby consent and authorize PA COUNSELING SERVICES to disclose to Lebanon County MH/ID/EI information from my participation in the Warrior Project. The specific information to be disclosed includes:

- \*Participation in the Warrior Project      Other \_\_\_\_\_
- \*Person Centered Plan      \_\_\_\_\_
- \*Safety Issues / Concerns      \_\_\_\_\_
- \*List of Treatment Providers      \_\_\_\_\_

I understand that this information is to be used for the purpose of CASE COORDINATION

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Parent or Primary Caretaker (optional)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

I, \_\_\_\_\_,

do hereby consent and authorize PA COUNSELING SERVICES to receive from Lebanon County MH/ID/EI information from my record(s). The specific information to be disclosed includes:

- \*Participation in the Warrior Project
- \*Copy of psychological/psychiatric evaluation      Other \_\_\_\_\_
- \* List of Treatment Providers      \_\_\_\_\_
- \*Safety Issues / Concerns
- \*Summary of Treatment
- \*Medical History & Physical

I understand that this information is to be used for the purpose of CASE COORDINATION

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Parent or Primary Caretaker (optional)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date