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 consent is subject to revocation at any time except to the extent that the lawful holder of the patient identifying information that is permitted to make the disclosure has already acted in reliance on it. 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Authorization was REVOKED on _____ (DATE) at _____ (TIME)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.