AUTHORIZATION TO RELEASE INFORMATION

EFFECTIVE FOR ONE YEAR: FROM: __________________ TO: ____________________

CLIENT'S NAME: _______________________________ **DOB: _________ SS#:** XXX-XX-_______

PARENT'S NAME: ____

ADDRESS: ____

TELEPHONE #: (_______) _________________ FAIRWOLD PROGRAM: ___________________

I AUTHORIZE FAIRWOLD TO RELEASE INFORMATION TO:

_________________________________ ____

Specific Organization/Specific Person *Address* *Phone Number*

INFORMATION TO BE RELEASED:

( ) Medical Examinations	( ) Educational Records	( ) Mental Health Information
( ) Treatment/Resiliency Plans	( ) Alcohol/Drug Treatment	___ Psychological Exam
( ) Laboratory Results	( ) Discharge Summary	___ Psychiatric Exam

DATE(S) OF SERVICE: ____ ( ) Other

PURPOSE: ____ ______________________

This information has been disclosed to you from records whose confidentiality is protected by federal and state law. Federal regulations (42 CFR Part 2), Pennsylvania Chapter 255.5 and Title 55 Chapter 5100 and 6400, and Family Educational Right Privacy Act prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for releasing medical or other information is not sufficient for this purpose. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer will be protected by this rule.

The undersigned has been informed of his/her right to:

1. Reviewed and understand the Notice of Privacy Practices;
2. This authorization is subject to revocation at any time, except to the extent that action has been taken to reliance on the authorization;
3. Inspect and receive a copy of the material to be released;
4. Request restrictions on how my health information is used and disclosed; and
5. Receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I understand its content. Fairwold may not condition treatment on obtaining this authorization from you.

Client's Signature: ____ Date: ______

Parent/Guardian's Signature: ____ Date: ______

Witness' Signature: ____ Date: ______

NOTE: Verbal consent is acceptable if the client/parent/guardian is physically unable to sign and understands the nature of this authorization and freely gives verbal consent. Print his/her name on the appropriate signature line above and record below the signature of two responsible persons who witness that such person understands the nature of this release and freely gives consent.

Witness's Signature: ____ Date: ______

Witness's Signature: ____ Date: ______

______ Copy of Consent Accepted _______ Copy of Consent Refused