ACCESS SERVICES
unlocking potential

Confidential Release of Information

Only fill out this section if revoking a current release:

Client Revoke Consent: _____

Information/Explanation

Revocation Date: _____

I, _____, hereby authorize Access Services Inc. to:

☐ release to ☐ obtain from _____ information from the record of:

Name: _____ DOB: _____

Information may be released to and/or obtained from:

Name of Person/Agency/Entity: _____

Address: _____

Phone Number: _____ Fax Number: _____

The information which may be released and/or obtained is limited to:

- ☐ Discharge Summary
- ☐ Psychiatric/Psychological Evaluation
- ☐ Social History
- ☐ Scholastic and/or School Records
- ☐ Physical Exam/Medical Records
- ☐ Treatment Plan
- ☐ Lab Results
- ☐ Progress Notes
- ☐ Written Order
- ☐ Medication
- ☐ Clinical Assessment
- ☐ Other _____

This information is being released and/or obtained for the purpose(s) of:

I understand that this authorization may include disclosure of information relating to ***mental health treatment, alcohol/substance abuse treatment, and confidential HIV/AIDS related information***. In the event that the health information described above includes any of these types of information, I specifically authorize the release of such information as indicated below:

Mental Health Treatment: ☐ Alcohol/Substance Abuse Treatment: ☐ HIV Related Information: ☐

Although I understand that I need not consent to the release of this information, I choose to do so willingly and voluntarily for the purpose(s) specified above. I have been informed of my rights (under the law) and I understand the nature of this authorization to release information subject to Section 111 of the Mental Health Procedures Act 50 P.S. Section 7111, and the Regulations (Sections 5100.31, 5100.33, 5100.34) pursuant to said Act by the Commonwealth of Pennsylvania. I also understand that my records are protected under the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282) and the Pennsylvania Drug and Alcohol Abuse Act. I understand that the provision of services to me shall not be conditioned on the signing of this release.

I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon) by written, dated communication to any representative of Access Services Inc. I understand that this right, and my other privacy rights, are detailed in the Notice of Privacy Practices.

This authorization is effective for no more than one year from the date it is signed by the consumer.
This authorization is effective from _____ to _____.

I have been offered a copy of this form and I have ☐ ACCEPTED ☐ DECLINED.

All items on this form have been completed and my questions about this form have been answered.

Client (if 14 and up): _____ Date: _____

Guardian/Representative (if less than 14 y/o): _____ Date: _____

Witness Signature: _____ Date: _____

Witness Name and Role/Relationship: _____

Staff Signature: _____ Date: _____

Signature Absent

☐ **Individual is unable to sign and verbally agreed** ☐ **Individual is absent** ☐ **Individual is not willing to sign**

Witness Name and Role/Relationship: _____

Witness of Signature: _____

Witness Name and Role/Relationship: _____

Second Witness Signature: _____

IN ACCORDANCE WITH FEDERAL REGULATIONS (42 CFR Part 2) and PENNSYLVANIA STATE REGULATIONS: This information has been/is being disclosed to you/us from records whose confidentiality is protected by Federal and State Law. Regulations limit our/your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Contact Information for Client Support

Enter natural and formal supports contact information if not listed above:

Effective Date	Organization (if applicable)	Name	Relationship	Emergency Contact? (Y/N)	Incident Notify? (Y/N)