Confidential Release of Information

Address/Telephone/Fax Number:

	Address	Telephone	Fax
☐	1100 Powell Street Norristown, PA 19401	610-277-4600	(F) 610-275-0216
☐	1201 DeKalb Street Norristown, PA 19401	610-279-9270	(F) 610-279-4146
☐	2500 Maryland Road, Ste 130 Willow Grove, PA 19090	267-818-2220	(F) 484-636-2598
☐	1217 DeKalb Street Norristown, PA 19401	610-270-0625	(F) 610-270-0750
☐	1109 DeKalb Street Norristown, PA 19401	610-272-3042	(F) 610-272-4922

I, ___________________________________, hereby authorize Central Behavioral Health 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:

- ☐ Clinical Assessment
- ☐ Psychiatric/Psychological Evaluation
- ☐ Progress Notes
- ☐ Medication
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Summary of Treatment to Date
- ☐ Physical Exam/Medical Records
- ☐ Lab Results
- ☐ Social History
- ☐ Scholastic and/or School Records
- ☐ 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 the Medical Director of Central Behavioral Health. I understand that this right, and my other privacy rights, are detailed in the Notice of Privacy Practices.

This authorization is effective from ____________________ to ___________________.
This authorization is effective for no more than five years from the date it is signed by the consumer.

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

(Continue onto next page)

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

Signature: ____ Date: ______________________________

☐ Signature of Consumer Age 14 or Older

☐ Signature of Parent, Other Closest Relative or Guardian of Consumer under Age 14
Relationship to Consumer of Parent, Closest Relative or Guardian: ____

☐ Consumer chose not to sign.

Witness of Signature: ____ Date: ____________________________

I, ____, am physically unable to provide my signature for release of information. I have given my verbal consent as verified by the following witnesses. These two witnesses verify that the above named consumer was physically unable to provide a signature and that he/she understands the nature of the release and freely gives his/her consent.

________________________	________________________	____________
Name	Signature	Date

____
Relationship to Consumer

________________________	________________________	____________
Name	Signature	Date

____
Relationship to Consumer

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.