



COUNSELING DEPARTMENT RELEASE OF INFORMATION

Name: _____ BD: _____

I authorize _____ to release clinical information pertaining to my
(Provider, Facility, EAP)

treatment or my child's treatment consisting of the following:

- _____ Intake/Assessment
- _____ Case Progress notes
- _____ Treatment Plan
- _____ Psychiatry notes
- _____ Discharge For/Summary
- _____ Medication log
- _____ Other (specify): _____

To: Name: _____
 Address: _____
 Telephone: _____

This release is for the purpose of _____

The authorization shall expire on* _____ (Date)

* If a date is not entered, authorization shall expire one year after the signature date. This consent is subject to revocation at any time, except that said revocation shall have no effect with respect to information which has already been released in reliance upon this consent.

Patient/Guardian/Legally Authorized Representative Signature	Name Printed or Typed	Date
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Witness Signature	Name Printed or Typed	Date
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This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR-part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.

7 Glassworks Rd, Greensboro, PA 15338	Phone: (724) 943-3308 Fax: (724) 943-4929
35 S. West St, Waynesburg, PA 15370	Phone: (724) 627-4309 Fax: (724) 627-0726
140 Church Street Ext., Suite 102, Rogersville, PA 15359	Phone: (724) 499-5188 Fax: (724) 499-5847
1227 Smith Twp State Rd., Burgettstown, PA 15021	Phone: (724) 947-2255 Fax: (724) 947-2477