

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 Probation/Parole (Adams County) information from my record(s). The specific information to be disclosed includes:

- | | | | |
|---|---|---|--|
| <input checked="" type="checkbox"/> Admission | <input type="checkbox"/> Summary of Treatment | <input type="checkbox"/> Treatment Plans/Aftercare Plans | <input type="checkbox"/> Medical History |
| <input checked="" type="checkbox"/> Attendance in Treatment | <input type="checkbox"/> Patient Data Form | <input type="checkbox"/> Initial Evaluation | <input type="checkbox"/> Medication Management Notes |
| <input checked="" type="checkbox"/> Progress in Treatment | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric/Psychological Evaluation | <input type="checkbox"/> Prescription Information |
| <input checked="" type="checkbox"/> Prognosis/Diagnosis/
Treatment Recommendations | <input type="checkbox"/> Progress Notes | | |
| <input type="checkbox"/> Other _____ | | | |

I, _____ do hereby consent to authorize **Pennsylvania Counseling Services** to receive from Probation/Parole (Adams County) information from my record(s). The specific information to be received includes:

- | | | | |
|---|---|---|---|
| <input checked="" type="checkbox"/> Admission | <input type="checkbox"/> Summary of Treatment | <input type="checkbox"/> Treatment Plans/Aftercare Plans | <input type="checkbox"/> Evaluations/Assessments |
| <input checked="" type="checkbox"/> Attendance in Treatment | <input type="checkbox"/> Patient Data Form | <input type="checkbox"/> Initial Evaluation | <input type="checkbox"/> Medication Management Notes |
| <input checked="" type="checkbox"/> Progress in Treatment | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric/Psychological Evaluation | <input type="checkbox"/> Prescription Information |
| <input checked="" type="checkbox"/> Prognosis/Diagnosis/
Treatment Recommendations | <input type="checkbox"/> Progress Notes | <input checked="" type="checkbox"/> Social History | <input type="checkbox"/> Medical History and Physical |
| <input type="checkbox"/> Other _____ | | | |

I understand that the information is to be used for the purpose of fulfilling probation/parole requirements

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 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 _____ at _____
DATE 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 Witness

Date

Patient has accepted rejected a copy of this document.

Revised 6/17