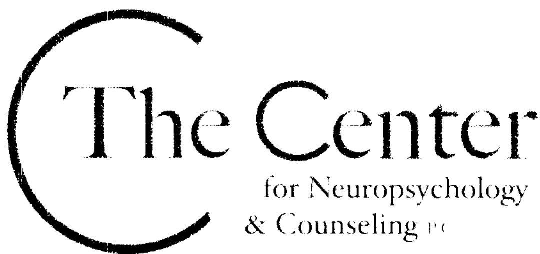

www.TheCenterinWarrington.com

p: 215-491-1119
f: 215-491-9119

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is for you to provide to us permission to release information to someone else. It can also be used to request others to release information to us - or both.

Who is the patient? Name ________________________________ Date of Birth: ________

What do you want to do?
- ❑ I want The Center to release information to someone.
- ❑ I want someone to release information to The Center
- ❑ Both - I want The Center to exchange information with someone

Who do you want us to send/receive/exchange information with? (If there are others, use a different sheet - one per person/organization)

____
Name of Individual or Organization

____
Address City, State, Zip

____
Phone Number Fax Number Email

Why are you requesting this? ________________________________

What information to you want shared? (check all that apply):

[ ] Developmental History	[ ] Psychological Evaluation/Reports	[ ] Treatment Summary
[ ] Discharge Summary	[ ] Lab/Test Results	[ ] Allow phone calls
[ ] Imaging reports (CT, MRI, etc.)	[ ] Mental Health History	[ ] Other: ________

[ ] Educational Records (Cumulative Folder: All report cards, all ER/RR's, PSSA/Keystones, current 504 Plan/IEP)

Treatment related to: (This requires specific consent. Check only the type of information you want shared)

[ ] AIDS/HIV [ ] Psychiatric Care [ ] Drug and alcohol treatment

I have been informed of the type of information being released; the benefits and disadvantages and I understand that services are not contingent upon my decision concerning the signing of this release. I understand that my records are protected under state and federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with state and federal law and regulations. I understand that The Center may deny this request under limited circumstances as provided for by state and federal law. This consent will expire after 12 months. However, I may revoke it at any time (in writing) except to the extent that action has already been taken. **Patients aged 14 or older who have consented to treatment need to sign this form. If a parent or guardian has consented to treatment then the parent/guardian should sign.**

________________________________ ________________
Signature of Patient (or Parent or Guardian) Date

1243 Easton Road, Suite 203
Warrington, PA 18976

555 Andorra Glen Court, Suite 9
Lafayette Hill, PA 19444