Methodist Services Community Counseling
51 Market Street, Bangor PA 18013 Phone: 610-588-9109 Fax: 610-588-5016
1708 Washington Boulevard Suite 102 Easton PA 18042 Phone: 610-252-2000 Fax: 610-252-1484

PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

I_____(with the date of birth of _____)
do hereby consent to and authorize Community Counseling Services to:

☐ Release information to: ☐ Obtain information from:

Person/Organization:_____

Relationship to Client:_____

Address:_____

Telephone:_____ Fax:_____

The information to be released includes:

☐ Psychiatric Evaluation ☐ Medication Record ☐ Bio-Psycho-Social Evaluation
☐ Treatment Plan ☐ Therapy Summary ☐ Discharge Summary ☐ Psychiatric Notes

Please Initial
_____ I authorize the release of my records understanding that they may include personal information pertaining to Drug abuse, Alcoholism, and or other substance abuse.
_____ I authorize the release of my records understanding that they may indicate the presence of a communicable or non-communicable disease such as HIV/AIDS.
_____ I authorize the faxing of my records.

I am authorizing this release of records for the purpose of:

____To coordinate treatment with other service providers
____To obtain insurance, employment or government benefits
____To enable judges, attorneys, probation/parole officers to support treatment goals or to make legal decisions on my behalf
____To coordinate treatment efforts with my family and other concerned persons
____Other: _____

This authorization shall be effective immediately and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance on it and, if not revoked in writing, will terminate in **one year from today**. I have been informed of my rights, subject to Title 5100 of the Pennsylvania Mental Health Procedures Act to inspect material to be released and of the confidentiality provisions of the Pennsylvania Drug & Alcohol Abuse Control Act and the HIV-Related Information Act if this pertains.

This form has been fully explained to me. I understand its contents, and I have been offered a copy.

Copy Offered: ☐ Accepted ☐ Declined

_____ _____
Client Date

_____ _____
Parent/Guardian Signature/Auth Rep Date

_____ _____
Witness to Signature Date

Note: This information has been disclosed to you from records whose confidentiality is protected by state law. State regulations limit your right to make any further disclosure without prior written consent of the person to whom it pertains.

Submit Form