

**PLAN of PA**  
**AUTHORIZATION FOR RELEASE OF INFORMATION**

(Phone) 610-687-4036 (Fax) 610-687-2716

I, \_\_\_\_\_ (DOB \_\_\_\_\_), hereby authorize the mutual exchange of confidential information between \_\_\_\_\_ and PLAN of PA, P.O. Box 154, Wayne, PA 19087.

The specific information to be released is (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Admission Records     | <input type="checkbox"/> Psychiatric Evaluation        |
| <input type="checkbox"/> Course of Treatment   | <input type="checkbox"/> Medication                    |
| <input type="checkbox"/> Lab Reports           | <input type="checkbox"/> Medical Records               |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Social History                |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Financial / Trust Information |
| <input type="checkbox"/> Current Status        | <input type="checkbox"/> Other _____                   |

And refers to my treatment on: \_\_\_\_\_

This information is required for the specific purpose of (check all that apply):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Case Management       | <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Residential Placement | <input type="checkbox"/> Other _____        |  |

All information released will be handled confidentially, in compliance with the Federal Privacy Act (PL 92-282) and the Pennsylvania Mental Health Procedures Act. Once your information is disclosed to PLAN of PA pursuant to this authorization, it may no longer be protected by HIPAA, a federal privacy law that applies to medical information. Nevertheless, all information released will be handled confidentially, in compliance with the Federal Privacy Act (PL 92-282) and the Pennsylvania Mental Health Procedures Act.

This authorization shall remain in effect throughout the period of time PLAN of PA is involved with my care and treatment. I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by oral or written, dated communication to PLAN of PA.

I have been informed of my rights, subject to sections 5100.31 and 5100.33 of the Pennsylvania Mental Health Procedures Act and subject to the Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material to be released.

I certify that all information contained on this form has been fully explained to me in the language I am most familiar with and that I understand its contents. I hereby release PLAN of PA, its agents, officers and employees from any and all liability arising out of the release of requested records.

\_\_\_\_\_  
Signature of Client \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness \_\_\_\_\_  
Date

Verbal consent is acceptable if the client is physically unable to provide a signature. A witness attested that the client understood the nature of the release and freely gave his/her verbal consent to release information from his/her case record.

Verbal consent freely given by: \_\_\_\_\_

\_\_\_\_\_  
Witness \_\_\_\_\_  
Title/Relationship \_\_\_\_\_  
Date

**PLAN DOES NOT SHARE PRIVATE INFORMATION ABOUT OUR CLIENTS EXCEPT AS PERMITTED BY LAW**