EMPOWERMENT Behavioral Health LLC

833 Park Rd. Suite 101

Wyomissing, PA 19610

Phone: 610-396-5094

Fax: 484-854-0715

**AUTHORIZATION TO RELEASE/OBTAIN INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB:\_\_\_\_\_\_\_\_\_\_), do hereby consent and authorize EMPOWERMENT Behavioral Health LLC to

\_\_\_ Send

\_\_\_ Receive

The following information:

\_\_\_ Medical History and Evaluation(s)

\_\_\_ Mental Health Evaluation(s)

\_\_\_ Developmental and/or social history

\_\_\_ Educational Records

\_\_\_ Progress Reports and/or Discharge Summaries

\_\_\_ Treatment Plans

\_\_\_ Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To/From: **Wilson School District**

Phone: 610-670-0180

The above information will be used for the following purposes:

\_\_\_ Planning appropriate treatment or programming

\_\_\_ Continue appropriate treatment or programming

\_\_\_ Determining eligibility for benefits or program

\_\_\_ Case review

\_\_\_ Updating files

\_\_\_ Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and am aware that this consent will automatically expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

 (one year from current date)

I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (Printed) Parent/Guardian (Printed) Witness Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Parent/Guardian Signature Witness Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date Date