Community Council Health Systems
4900 Wyalusing Avenue
Philadelphia, PA 19131
Phone: 215-473-7033

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

I _____ hereby authorize **Community Council Health Systems**
(Print name of person signing) **(Name of agency)**

CHECK ONE

[ ] to release to

[ ] to obtain from _____

(Name of person & agency / Relationship to individual / Contact Information)

concerning date(s) of service from _____ to _____ regarding

services to _____, Date of Birth: _____ SS#(last 4 digits)_____
(Print name of individual)

The information to be released is limited to (please check appropriate items):

[ ] Admission Summary [ ] Psychiatric Evaluation

[ ] Discharge Summary [ ] Psychological Evaluation

[ ] Treatment Plan/Summary [ ] Medication List/ Notes

[ ] Other (please specify): _____

I authorize this information to be disclosed only for the following purpose (Please check box below):

[ ] Continuity of Care [ ] Personal use [ ] Social Security/ Attorney [ ] Other (specify):_____

This consent will begin on _____ and end on _____ (Not to exceed 1 year). I understand that the information in my record may contain information relating to sexual transmitted diseases, AIDS or HIV, drug and alcohol use /abuse as well as mental health treatment. I also understand that I may stop/cancel/revoke this authorization at anytime in writing to the HIM Specialist except to the extent that the person who is to make the disclosure has already acted in reliance to the individual's consent.

_____ _____
(Individual Signature (if 14 or older)---Date) **(Signature of person giving consent for individual ---Date)**

_____ _____
(Witness Signature---Date) **(Relationship to the individual)**

(Parent or guardian must sign for a child who is EITHER under the age of 14, OR BOTH intellectually disabled and under the age of 18.)

_____
(Mark of oral consent)

_____
(2nd Witness Signature for oral consent---Date)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose CONFIDENTIALITY is protected by STATE AND FEDERAL LAW STATUES. STATE AND FEDERAL REGULATIONS PROHIBITS you from making any further disclosure of this information except with SPECIFIC WRITTEN CONSENT of the person to whom it pertains [42 CFR, part 2; 55 PA Code § 5100.34 (d)].

I do not want a copy of this form [ ]
I want a copy of this form [ ]

_____
(Individual/ Person giving consent Signature---Date)