**ABC COUNTY Children’s Bureau**

**(Integrated Human Services Release)**

CONSENT TO **RELEASE** CONFIDENTIAL INFORMATION

I, (Client) (D.O.B.) give my consent to the following:

[ ]  ABC County Children’s Bureau [ ]  XYZ provider Drug and Alcohol Case Management

[ ]  ABC Drug and Alcohol Agency

[ ]  ABC County Behavioral Health and Development Services

[ ]  ABC Case management and Supports Inc.

[ ]  Treatment Provider: (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other: (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other: (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To communicate with and disclose to one another the following information:

[ ]  Assessment Recommendation [ ]  Background Information

[ ]  Dates and Results of Drug Testing [ ]  Dates of Service and Attendance

[ ]  My Presence in Treatment [ ]  My Prognosis and Diagnosis

[ ]  Incidence of Relapse

[ ]  The nature of the project involved and recommendations for supportive services

[ ]  Other: (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of the disclosure is to inform the person(s) and agencies listed above of my attendance in treatment and compliance. This form has been explained to me and by signing it, I am verifying my understanding that: My records are protected under the state and federal regulations. I understand that the above information has been disclosed from records where federal and state law protect confidentiality, federal regulations (42 CFR part 2) and state regulation (4 PA code 255.5) prohibit any further disclosure, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. This consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it.

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purpose specified above. The duration of this authorization will expire after three hundred and sixty-five days (365), unless I specify a date, event, or condition upon which it will expire sooner. I understand that I may revoke this consent at any time verbally or in writing except to the extent action has been taken in reliance on my consent.

I have been offered a copy of this form and I have [ ] Accepted [ ] Refused

Signature of Client Date:

Signature of Witness Date:

**If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by Pennsylvania law.  Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act.  A general authorization for the release of medical or other information is not sufficient for this purpose.**

**If mental health records are being released as permitted by the Mental Health Protection Act, I understand that I have a right subject to 55 Pa. Code § 5100.33, to inspect the material to be released.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have REVOKED this consent on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.