Fax: (570) 392-6143

3835 Chestnut St.
Emmaus, PA 18049

Phone: (484) 232-5288

428 South 7th St.
Lehighton, PA 18235

Phone: (610) 900 4234

Authorization To Release/Obtain Health Information

I, _____(DOB:_____), hereby authorize_____to release/obtain information from Medical records pertinent to the Mental Health/Mental Retardation; Drug/Alcohol treatment; and or HIV/AIDS treatment of: _____.

(Individual's Name)

ROI Valid from _____ until _____, or one year from date signed.

_____

(Name of Person/Organization/Facility obtaining records from)

_____

(Address)

The information which may be released is limited to the <u>MOST RECENT:</u>

_____ Discharge Summary **_____ Blood work**

_____ Psychiatric Assessment **_____ Other**

_____ Medication Log **_____**

The purpose or need for such disclosure is:_____
Behavioral Health services may not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign authorization except if my treatment is related to research or if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Hereby release Behavioral Health Services and all other persons or legal entities of facilities, related in any way to the release of said information from all responsibility and liability for acting upon this authorization and I intend to be legally bound hereby.

Individual, Parent, Legal Guardian Signature_____Date_____

Personal Representative Signature _____Date_____

Witness/Staff Member Signature _____Date_____

If any person physically unable to provide a signature desires to consent to this release, print his/her dame on the appropriate signature line above and record below the signature of two responsible persons who witness that such a person understand the nature of this release and freely gave his/her consent.

Witness Signature _____Date_____

Witness Signature _____Date_____