RELEASE OF INFORMATION

BUCKS SUPPORT SERVICES

EATING SUPPORT COLLABORATIVE | LGBTQ CENTER | RECOVERY CENTER | FAMILY CENTER

If you would like information to be shared or discussed with additional healthcare, psychiatric or medical providers, family members or other parties where sharing information is warranted, please complete this form.

I, _____, Date of Birth, ____/____/_____, Phone, ____-____-_____

hereby authorize _____, and Bucks Support Services personnel to release and exchange information pertaining to my or my child's evaluation and therapy sessions to (please list business, person, and call contact information available):

_____

_____

The information that I would like to be shared or discussed includes the following checked topics:

- ☐ Session dates, times and attendance
- ☐ Psychiatric evaluation outcomes including diagnosis
- ☐ Psychological evaluation outcomes including diagnosis
- ☐ Treatment plan
- ☐ Progress and treatment notes
- ☐ Prescription and medication
- ☐ Substance use
- ☐ HIV/AIDS, other communicable disease status
- ☐ Legal proceedings and updates
- ☐ Payment and financial
- ☐ Other: _____

The purpose(s) for the shared or discussed information:

- ☐ Continuation and/or coordination of care
- ☐ Professional collaboration
- ☐ Personal request
- ☐ Legal or court proceedings
- ☐ Other: _____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (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 after (1 year) this consent automatically expires. 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. By signing below, I certify that this form has been fully explained to me and that I understand the content, risks and limitations.

Signature: _____ Date: ____/____/_____