R.E.A.C.H.
Reaching Educational Achievements with Clinical Mental Health
300 West Campus Ave.
Davidsville, PA 15928
Office: 814.479.4014 Fax: 814.509.8106

Consent for Release of Information Form

I, hereby authorize R.E.A.C.H. Inc., to:

____send ____receive, the following, ____to ____from the following agency or person:

Agency

Name Address City State Zip Phone Fax

For treatment and/or services from _____ to _____.

Information/Documents

____Academic testing ____Behavior programs ____Case notes/Therapy notes

____Intelligence testing ____Medical reports ____Progress reports

____Psychological reports ____Most recent medical record ____Entire record

____Verbal communication ____Most updated medication list ____Other:_____

Purpose

The above information will be used for the follow:

____Planning appropriate treatment or program ____Determining eligibility for benefits

____Continuing appropriate treatment or program ___Case review

____Other (specify)_____ ___Updating files

Signature(s)

"I understand that I may revoke this consent at any time by providing written notice to the office address listed above. However, this revocation will not be effective to the extent that action was taken by R.E.A.C.H. Inc. in reliance on the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. After one year this consent automatically expires. I understand that my psychologist/psychiatrist/therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I have been informed what information will be given, its purpose, and who will receive the information.

This consent to Release Information is valid from _____ to _____.

_____ _____

Client Date Parent/Guardian Date

_____ _____

Witness Date Person informed client of their rights Date

___Unable to sign therefore giving verbal consent to release information _____(person giving verbal consent)

_____ _____

Witness Date Witness Date

Name: DOB:

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Name: DOB: