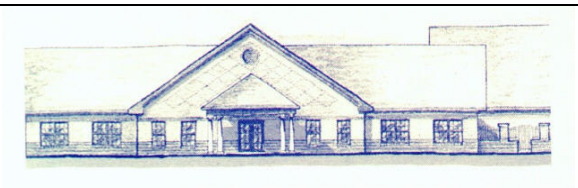

The Children's Aid Home Programs of Somerset County, Inc.
P.O. Box 1195, 1476 North Center Avenue
Somerset, Pennsylvania 15501
814-443-1637, FAX: 814-445-8481

AUTHORIZATION / CONSENT TO DISCLOSE HEALTH INFORMATION

Client/Resident/Consumer Name: _____

Medical Record Number _____ Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

PRIVACY COMPLAINT OFFICER
CHILDREN'S AID HOME PROGRAMS
P.O. BOX 1195
SOMERSET, PA 15501

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ Psychological/Psychiatric Evaluation
- ❑ Medication records
- ❑ Treatment plans
- ❑ Discharge plans
- ❑ Progress notes
- ❑ Treatment orders
- ❑ Most recent history and physical
- ❑ Most recent discharge summary
- ❑ Laboratory results
- ❑ Immunization records
- ❑ Consultation reports
- ❑ Billing records
- ❑ Entire record
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

4. The following individual or organization is authorized to make the disclosure: (entity not identified in #2)

Individual's Name: _____
Organization's Legal Name: _____
Address: _____
_____
City, State, Zip: _____

5. This information may be disclosed to and used by the following individual or organization

Individual's Name: _____
Organization's Legal Name: _____
Address: _____
_____
City, State, Zip: _____

For the following purpose (Check all that apply):
_____ To develop a diagnosis, treatment, and rehabilitation plan
_____ To coordinate medical, psychological, and social rehabilitation processes
_____ Reimbursement
_____ Other (please specify): _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the privacy complaint officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in three months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive services. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact this agency's privacy/complaint officer.

_____ _____
Signature of Consumer or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Consumer Signature of Witness

Parent/Guardian signature is required if consumer is under the age of fourteen years old.

_____ _____
Parent/Guardian Date

For those individuals physically unable to sign this authorization.

I, _____, am physically unable to sign this authorization. My verbal consent to the above authorization and my verbal statement of my understanding of this authorization has been witnessed by the two (2) individuals whose signatures appear below.

Name: _____ Name: _____

Signature: _____ Signature: _____