20231 Paint Boulevard
Shippenville, PA 16254
(814) 226-1159
Fax (814) 227-2876

850 Leonard Street
Clearfield, PA 16830
(814) 205-4004
Fax (814) 205-4013

CONSENT FOR RELEASE OF INFORMATION

I _____,_____, authorize Project Point of Light
(Client's Name) (Client's DOB)
to disclose and/or obtain from: _____
_____
(Name of Person or Title of Person or Organization)
the following information:

Description of Information to be Disclosed (Check all that apply)

- ○ Assessment
- ○ Diagnosis
- ○ Psychosocial Evaluation
- ○ Psychological Evaluation
- ○ Psychiatric Evaluation
- ○ Treatment Plan or Summary
- ○ Current Treatment Update
- ○ Medication/Management Information
- ○ Presence/Participation in Treatment
- ○ Probation/Parole Information
- ○ Nursing/Medical Information
- ○ Toxicological Reports/Drug Screens
- ○ Educational Information
- ○ Discharge/Transfer Summary
- ○ Continuing Care Plan
- ○ Progress in Treatment
- ○ Demographic Information
- ○ Legal Information
- ○ Transportation by_____
- ○ Other_____

These records concern the time between _____and_____and should be forwarded to the address on the letterhead of this form. The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose please specify:_____
_____

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

☐ Do not release HIV related information ☐ Do not release drug/alcohol information

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending a written notice to Project Point of Light. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose the information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:_____
_____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time except to the extent that action based on this consent has already been taken. The consent will expire automatically after one year from the date on which it is signed.

_____ _____
Client's Signature (14 years of age or older) Date

_____ _____
Signature of Parent Guardian if child under 14 Therapist's Signature Credentials

o I do want a copy of this release o I do not want a copy of this release

---

Oral Consent
(Not Applicable to HIV Related Information)
For Persons Physically Unable to Provide a Signature
I witness that the person understood the nature of this release and freely gave his/her oral consent.

Date of Signature:	Signature of Witness:
Date of Signature:	Signature of Witness:

Client Name: Client ID: