Western Pennsylvania Psych Care
1607 Third Street
Beaver, PA 15009
Phone: 724-728-8411 Fax: 724-728-8410

CONSENT TO EXCHANGE OR RELEASE INFORMATION

Permission is hereby granted to release or obtain information from:

Western Pennsylvania Psych Care **1607 Third Street** **Beaver, PA 15009**	**TO AND FROM**	**Name/Company:** ___________________ **Address:**____________________________ ____________________________________ **Phone:** ____________________________

Regarding: ____ ________________
Patient Name **Date of Birth**

For the purpose of: Coordination of Care

Time Period Requested: ________________________ - __________________________
(Start Date) (End Date)

Information Allowed To Be Released Or Obtained (check all that apply):

- ☐ **Psychiatric Evaluation**
- ☐ **Psychological Evaluation**
- ☐ **Medical Record**
- ☐ **School Records**
- ☐ **Social History**
- ☐ **Progress Notes**
- ☐ **Appointment related information**
- ☐ **Discharge Summaries**
- ☐ **Psychiatric assessments**
- ☐ **Treatment Plan**
- ☐ **Monthly treatment reviews**
- ☐ **Treatment History**
- ☐ **Current treatment related concerns**
- ☐ **Medical History and Physical Examination**

Method of Release: ______ **Copies Only** ______ **Verbal Only** ___X___**Copies and Verbal**

Sensitive Information:

I understand that my medical record may contain information relating to:

AIDS ☐ I **Give Consent** ☐ I **DO NOT give consent** for use and disclosure of this type of information
HIV ☐ I **Give Consent** ☐ I **DO NOT give consent** for use and disclosure of this type of information
Drug and/or alcohol use ☐ I **Give Consent** ☐ I **DO NOT give consent** for use and disclosure of this type of information

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I have read this authorization and understand the content and the purpose. I understand that I am not obligated to sign the permission for the Release of Information. I understand that I may cancel this authorization at any time

This authorization will expire 1 year from the date of signature or upon request from the consume, whichever is sooner.

_______________________________ _______________________ ____________________
Signature of Person Giving Consent **Relationship To Consumer** **Date**

_______________________________ _______________________
Consumer Signature if > 14y.o. **Date**

_______________________________ _______________________
Witness Signature **Date**