

INDEPENDENT EDUCATIONAL EVALUATORS OF AMERICA, LLC

AUTHORIZATION TO RELEASE INFORMATION

I do hereby consent and authorize _____ to disclose to:

Name: Independent Educational Evaluators of America, LLC
Address: 2818 Lititz Pike, Lancaster, PA 17601-3322
Phone Number: (717-569-6223
Fax Number: (717-560-9931

Information from my record(s) related to my identity, diagnosis, prognosis and treatment (including diagnosis and/or treatment for mental health, drug/alcohol abuse and/or HIV-related information). The specific information to be received / disclosed includes: (Please mark an X for each document.)

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Initial Evaluation/Admission Note
<input type="checkbox"/> Special History	<input type="checkbox"/> Psychological Evaluation/Summary
<input type="checkbox"/> Medical Record	<input type="checkbox"/> Homebound Instruction Report
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Patient Data Form
<input type="checkbox"/> Outpatient Treatment Summary	<input type="checkbox"/> Referral/Treatment Summary
<input type="checkbox"/> Discharge Instructions	<input type="checkbox"/> Psychiatric Evaluation/Summary
<input type="checkbox"/> Alcohol and Other Drug Consult	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Medication Sheets
<input type="checkbox"/> Any and all Records	
<input type="checkbox"/> Other (list specific items): _____	

I understand this information is to be used for the purpose of: (check as many as apply) Diagnosis Continuity of Care Treatment Planning Discharge Planning Further Evaluation Other

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Public Law 93-282, and/or Code of Federal Regulations, 42 (Drug and Alcohol treatment records), and/or Act 148 (Confidentiality of HIV-related Information Act). I understand the nature of this release and understand that I have the right to inspect material that is to be released. I understand that I may revoke this authorization at any time by notifying Margaret J. Kay, Psychologist. This authorization shall be effective immediately and shall expire in one year from the date hereof or on _____ and is valid for all record documentation during the effective period.

I understand that I have the right to request a copy of this authorization and that I may revoke my consent at anytime by written notice. Check one: Patient accepted copy Patient declined copy

PATIENT'S SIGNATURE

DATE

RELATIONSHIP TO PATIENT

WITNESS

THIS PORTION TO BE COMPLETED WHEN PATIENT IS UNABLE TO GIVE WRITTEN CONSENT

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the above information. The patient has also been informed that he/she may verbally revoke this authorization at any time.

Signature of Witness/Date

Signature of Witness/Date

PATIENT NAME: _____

DATE OF BIRTH: _____