YORK COUNTY HUMAN SERVICES DEPARTMENTS
INFORMATION RELEASE FORM

I hereby authorize the following to release information to:
York/Adams County Health Choices
100 West Market Street, York, PA 17401
(Name and complete address of Agency/Individual)

and/or to receive information from:
York/Adams County MH/IDD
100 West Market Street, York, PA 17401
(Name and complete address of Agency/Individual)

Regarding the Record of Name: _____ **DOB:** _____

Address: _____

The information released will be limited to any and all records requested below for the date range: Current Date-1 year later
Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

_____ Evaluation-Select: ☐ Psychological ☐ Psychiatric ☐ Drug and Alcohol ☐ Offender ☐ _____

_____ Report Card/Attendance	____ Behavior reports	____ IEP/Evaluation Report	____ Birth Certificate (copy)
_____ Medical/Hospitalization Records	____ Physical Exams	____ Immunizations	____ Dental Exams
_____ Treatment Plan/Recommendations	____ Progress Reports	____ Attendance/Participation	____ Discharge Summary
_____ Probation/Parole Conditions	____ Childline	____ Drug Test Results	____ Accurint/Family Finding
_____ County Assistance/Welfare	____ Pay Stub(s)	____ Social Security Benefits	____ Insurance Information

_____ Residency Confirmation-Rent Payment, Lease or Mortgage _____

_____ Financial Release-explanation: _____

X Other: Clinical and financial information needed to make a decision on Children & Adolescent Support Services Application

The information will be used for the following purpose(s): ☒ Assessment ☐ Provision of Service ☒ Determining eligibility

This release automatically expires **1 year from date of signature** or when the above-named person ceases to be a consumer of the agencies selected, whichever occurs sooner. The authorization for the release of information may be revoked at anytime. To revoke this authorization, please notify the York County Human Services Agency identified at the top of the release in writing.

I understand that I do not have to consent to the release of information. I understand that treatment, payment, enrollment or eligibility for services are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services.

I understand that there may be a risk that the person/organization receiving my information could possibly redisclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I voluntarily choose to release the information. I acknowledge that I fully and completely understand the content of this form.

Please read carefully:

- I have the right to receive a copy of this signed release form.
- If the consumer is 14 years of age or older, the consumer must sign and date the form.
- If the consumer is 14 years of age or younger, the consumer's parent or legal guardian must sign and date the form unless an exception exists under state or federal law.
- If the consumer is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship. ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

Printed name	X Signature of client/parent/guardian	Relationship	Date
Printed name of staff	X Signature of staff		Date

Notice to the recipient of these records

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations limit your ability to make any further disclosure of this information without the prior written authorization of the person to whom it pertains.

YORK COUNTY HUMAN SERVICES DEPARTMENTS
INFORMATION RELEASE FORM

I hereby authorize the following to release information to: York/Adams County Health Choices

100 West Market Street, York, PA 17401
(Name and complete address of Agency/Individual)

and/or to receive information from: York/Adams Service Access & Management

1305 E. Market Street, Suite B, York, PA 17403
(Name and complete address of Agency/Individual)

Regarding the Record of Name: _____ **DOB:** _____

Address: _____

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Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

_____ Evaluation-Select: ☐ Psychological ☐ Psychiatric ☐ Drug and Alcohol ☐ Offender ☐ _____

_____ Report Card/Attendance ____ Behavior reports ____ IEP/Evaluation Report ____ Birth Certificate (copy)

_____ Medical/Hospitalization Records ____ Physical Exams ____ Immunizations ____ Dental Exams

_____ Treatment Plan/Recommendations ____ Progress Reports ____ Attendance/Participation ____ Discharge Summary

_____ Probation/Parole Conditions ____ Childline ____ Drug Test Results ____ Accurint/Family Finding

_____ County Assistance/Welfare ____ Pay Stub(s) ____ Social Security Benefits ____ Insurance Information

_____ Residency Confirmation-Rent Payment, Lease or Mortgage _____

_____ Financial Release-explanation: _____

X Other: Clinical and financial information needed to make a decision on Children & Adolescent Support Services Application

The information will be used for the following purpose(s): ☒ Assessment ☐ Provision of Service ☒ Determining eligibility

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Printed name	X Signature of client/parent/guardian	Relationship	Date
Printed name of staff	X Signature of staff		Date

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YORK COUNTY HUMAN SERVICES DEPARTMENTS
INFORMATION RELEASE FORM

I hereby authorize the following to release information to: York/Adams County Health Choices

100 West Market Street, York, PA 17401
(Name and complete address of Agency/Individual)

and/or to receive information from: Host Home Provider

Host Home Provider's Address
(Name and complete address of Agency/Individual)

Regarding the Record of Name: _____ **DOB:** _____

Address: _____

The information released will be limited to any and all records requested below for the date range: Current Date-1 year later

Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

_____ Evaluation-Select: ☐ Psychological ☐ Psychiatric ☐ Drug and Alcohol ☐ Offender ☐ _____

_____ Report Card/Attendance ____ Behavior reports ____ IEP/Evaluation Report ____ Birth Certificate (copy)

_____ Medical/Hospitalization Records ____ Physical Exams ____ Immunizations ____ Dental Exams

_____ Treatment Plan/Recommendations ____ Progress Reports ____ Attendance/Participation ____ Discharge Summary

_____ Probation/Parole Conditions ____ Childline ____ Drug Test Results ____ Accurint/Family Finding

_____ County Assistance/Welfare ____ Pay Stub(s) ____ Social Security Benefits ____ Insurance Information

_____ Residency Confirmation-Rent Payment, Lease or Mortgage _____

_____ Financial Release-explanation: _____

X Other: Payment verification for requested service/support under the Health Choices Children & Adolescent Support Program

The information will be used for the following purpose(s): ☐ Assessment ☒ Provision of Service ☒ Payment verification

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Printed name	X Signature of client/parent/guardian	Relationship	Date
Printed name of staff	X Signature of staff		Date

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