

YORK COUNTY DEPARTMENT OF PROBATION SERVICES



45 NORTH GEORGE STREET
YORK, PENNSYLVANIA 17401
ADULT OFFICE 2nd FLOOR
717-771-9602 FAX 717-771-9846
JUVENILE OFFICE 3rd FLOOR
717-771-9567 FAX 717-852-4925



I, _____ do hereby authorize York County Adult Probation
to disclose to _____ the following information:

- _____ Current/past involvement in treatment
- _____ Current/past drug and alcohol usage
- _____ Mental health treatment and history
- _____ Legal status
- _____ Involvement with other social service agencies or prison programs

This information will be used for the following purpose(s):

- _____ Presentence Investigation
- _____ To enable the Probation/Parole Officer to make or support treatment goals

This consent to release information will remain in effect for:

- _____ Ninety (90) days after the date specified by signature
- _____ Subject to the following time frame: **One year from date of consent or upon maximum supervision date**

I understand by law I have no obligation to release this information. I choose to do so willingly and voluntarily. I acknowledge by my signature that I understand consent remains in effect until the above date or event, unless I specifically revoke it by written notice. I have read this form or had it read to me and explained to me and I understand its contents.

I have been offered a copy of this form and accepted/rejected it. (please circle one)

Client Signature _____ Date: _____

Witness Signature _____ Date: _____

PROHIBITION OF DISCLOSURE: Federal and State regulations prohibit any further disclosures of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

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I, _____ do hereby authorize _____
(name and date of birth) (name of agency/institution)

_____ to disclose to _____
(address of agency/institution) (name)

of the York County Adult Probation Department, the following information (only those sections checked and initialed by the client.

- _____ Presence in Treatment
- _____ Psych/social Assessment
- _____ Diagnosis, Progress Report, Prognosis
- _____ Psychiatric Evaluation
- _____ Psychological Evaluation
- _____ Discharge Summary
- _____ Other _____
(specify)

This information will be used for the following purpose(s):

- _____ Presentence Investigation
- _____ To enable the Probation/Parole Officer to make or support treatment goals

This consent to release information will remain in effect for:

- _____ Ninety (90) days after the date specified by signature
- _____ Subject to the following time frame _____

I understand by law I have no obligation to release this information. I choose to do so willingly and voluntarily. I acknowledge by my signature that I understand consent remains in effect until the above date or event, unless I specifically revoke it by written notice. I have read this form or had it read to me and explained to me and I understand its contents.

I have been offered a copy of this form and accepted/rejected it. (please circle one)

Client Signature _____ Date: _____
 Witness Signature _____ Date: _____

PROHIBITION OF DISCLOSURE: Federal and State regulations prohibit any further disclosures of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

**AUTHORIZATION FOR RELEASE OF
MEDICAL AND PSYCHOLOGICAL INFORMATION**

To:

Date:

From:

OFFENDER INFORMATION

Offender's Full Name (last, first, MI):

SS Number: (if available)

DOB:

I, _____ hereby authorize The York County Adult Probation Department to release to any authorized agent of the County of _____, for the purpose of transferring my probation, parole or other supervision, any and all of my medical reports, records, hospital records, psychiatric or mental health records, prescription files and drug records and to furnish any and all information relating to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, drug or alcohol use, sickle cell disease, HIV/AIDS or sexually transmitted diseases and any information that may be requested concerning my condition. Furthermore, I authorize any physician, nurse or other medical technician who has attended to or treated me, or any hospital in which I have been treated, to furnish any and all information, which pertains to examinations, x-rays, CT scans, pathology reports, pathology slides, treatment rendered, findings and opinions as to my condition to release to any authorized agent of the County of _____.

In accordance with HIPPA regulations, specifically, 45 CFR 174.508, I have been advised and agree to the following:

- (A) Purpose of the request: Transfer of Supervision for Adult Offender Supervision;
- (B) Dates of Service: All dates of treatment while under supervision;
- (C) I have the right to revoke this authorization at any time by a letter to the County of York, but if I do so that such revocation may be considered a violation of the terms and conditions of parole, probation or other supervision for which I may be returned to the Court of Common Pleas.
- (D) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs when the prohibition on conditioning of authorizations in paragraph (b)(4) of 45 CFR 174.508 applies;
- (E) Information disclosed pursuant to authorization is subject to redisclosure by the recipient and is no longer protected by federal regulations;
- (F) I have been provided a copy of this authorization;
- (G) This authorization will expire upon the occurrence of the following event or condition: Written notice of revocation provided to the County of York or upon the expiration or termination of supervision.
- (H) The County of York, its programs, services, employees, officers and contractors and the County of _____, its programs, services, employees, officers and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Offender Signature: _____

Date: _____

Printed Name: _____

Witness: _____

Date: _____

Printed Name: _____