PERMISSION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ **DOB:** _____

I hereby grant permission to the following organization to release and receive confidential information to Jewish Family Service of Greater Harrisburg, Inc.:

_____ _____

Name of Recipient Address/Phone Number/Fax Number

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. Please indicate if you would like this information released and/or obtained:

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No
HIV or AIDS Testing and Results	☐ Yes	☐ No
Behavioral or Mental Health Records	☐ Yes	☐ No

- Please indicate the specific information that may be released:
  - ☐ Report of Most Recent Physical Examination
  - ☐ Medical Records
  - ☐ Summary of contacts and content
  - ☐ Other (please specify) _____
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services at Jewish Family Service of Greater Harrisburg, Inc.
- The information covered by this release may be exchanged through **Oral** or **Written** Communication.
- The information covered by this release shall be used for the purpose of **Treatment Planning and Coordination** unless another purpose is specified here: _____.
- The information obtained through this release may not be released to any third party.
- This release expires 6 months from the date signed unless otherwise indicated: _____.
- It may be revoked at any time in writing by the person giving consent.

_____ _____

Signature of Client (if 14 years of age or older) or Parent/Guardian/Authorized Representative — Date

_____ _____

Print Name of Client (if 14 years of age or older) or Parent/Guardian/Authorized Representative — Relationship to Client

_____ _____

Signature of Witness — Date