R.E.A.C.H.
Reaching Educational Achievements with Clinical Mental Health
600 Harlan Ave. Johnstown, PA 15905
Office: 814.288.5757 ext.5004   Fax: 814.509.8106

Consent for Release of Information Form

I, hereby authorize R.E.A.C.H. Inc., to:

____send ____receive, the following, ____to ____from the following agency or person:

Agency

Name	Address	City	State	Zip	Phone	Fax

For treatment and/or services from ______________________ to ______________________.

Information/Documents

____Academic testing
____Behavior programs
____Case notes/Therapy notes
____Intelligence testing
____Medical reports
____Progress reports
____Psychological reports
____Most recent medical record
____Entire record
____Verbal communication
____Most updated medication list
____Other:___________________

Purpose

The above information will be used for the follow:

____Planning appropriate treatment or program
____Continuing appropriate treatment or program
____Other (specify)_____________________________
____Determining eligibility for benefits
___Case review
___Updating files

Signature(s)

"I understand that I may revoke this consent at any time by providing written notice to the office address listed above. However, this revocation will not be effective to the extent that action was taken by R.E.A.C.H. Inc. in reliance on the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. After one year this consent automatically expires. I understand that my psychologist/psychiatrist/therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I have been informed what information will be given, its purpose, and who will receive the information.

This consent to Release Information is valid from __________________________ to ____________________________.

____   ____

Client   Date   Parent/Guardian   Date

____   ____

Witness   Date   Person informed client of their rights   Date

___Unable to sign therefore giving verbal consent to release information _________________________________(person giving verbal consent)

____   ____

Witness   Date   Witness   Date

Name: DOB: