Pennsylvania Counseling SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

My/our signature(s) as listed below, confirms that I/we understand that Student Assistance Program services are not treatment, but rather include an assessment and potentially in-school support or educational groups to assist the student.

I, _____(Student) do hereby consent and authorize PENNSYLVANIA COUNSELING SERVICES to disclose to _____SAP Team_____ information from my assessment records for the purpose of coordination of care and/or educational and support services. The specific information to be disclosed includes:

_X_ SAP Assessment Summary (includes recommendations)

___ Other (specify) _____

I understand that this information is to be used for the purpose of coordination of care and/or educational and support services

_____ _____

Student Signature (optional if Student is under age 14) Signature Parent or Primary Caretaker (optional if Student is age 14 or older)

_____ _____

Signature of Witness Date

This authorization will expire at the end of the current school year.

I understand that I have the right to revoke this authorization at any time verbally or in writing.
This authorization was revoked on_____
Staff Signature (For verbal revocation, client not present)_____
Student Signature/Guardian/POA signature (If Present)_____

I, _____(Student) do hereby consent and authorize PENNSYLVANIA COUNSELING SERVICES to **receive from** _____SAP TEAM_____ the following information:

___X_ Other (specify): __case management_____

I understand that this information is to be used for the purpose of coordination of care and/or educational and support services

_____ _____

Student Signature (optional if Student is under age 14) Signature Parent or Primary Caretaker (optional if Student is age 14 or older)

_____ _____

Signature of Witness Date