Consent for Release or Exchange of Information

770 East Pittsburgh Street
Greensburg, PA 15601
724-837-1808

This Consent form is for routine use, (service, payment, and health care operations) and is not required under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This disclosed information may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

Client Name: _____ **Document Type:** IDD- 08

Date of Birth: _____ **Chart Number:** _____

I CONSENT TO THE REQUEST FOR AND THE RELEASE OF MY RECORDS AND/OR EXCHANGE OF INFORMATION BETWEEN THE PARTIES BELOW

PROVIDER NAME: Regional Integrated Human Services (RIHS)
STREET ADDRESS: 766 East Pittsburgh Street
CITY: Greensburg STATE: PA ZIP: 15601

Westmoreland Casemanagement and Supports, Inc.
Attention: Privacy Officer
770 East Pittsburgh Street
Greensburg, PA 15601

Purpose of Request or Disclosure:

[X] Referral for Service	[X] Treatment Planning	[X] Insurance/Legal
[X] To Evaluate Need for Service	[X] Ongoing Case Management	[ ] Other:

Specific Information Being Requested:

[X] Outpatient/Inpatient Records	[X] Psychiatric/Psychological History	[X] Physical Health/Medical Records
[X] Education/IEP/Vocational	[X] Verbal/Written Communication	[X] Other:

Specific Dates of Documents Being Requested: _____ Through _____

Specific Information Being Disclosed:

Behavioral Health

[ ] Referral Packet	[ ] Verbal/Written Communication
[ ] Other:	[ ] Specify Document(s):

Intellectual Developmental Disabilities

[X] Referral Packet	[ ] Prioritization of Urgency of Need for Services report (PUNS)	[X] Support Intensity Scale Assessment (SIS)
[X] Individual Support Plan (ISP)	[X] Verbal/Written Communication	[X] Other: Initial eligibility and revaluation documents

Early Intervention

[ ] Individual Family Service Plan (IFSP)	[ ] Evaluation Report (ER)
[ ] Verbal/Written Communication	[ ] Other:

This Consent authorizes release of the above requested information and includes permission to make photocopies and/or examination of the records. I have been informed that I may revoke this Consent at any time by writing to the Privacy Officer at Westmoreland Casemanagement and Supports, Inc., except to the extent that action has already been taken. **This release will expire in 365 days from date of my signature below.**

I understand that my record may contain information regarding all aspects of my treatment, including psychiatric and psychological information, drug and/or alcohol information as well as information regarding Acquired Immune Deficiency Syndrome (AIDS) and test or treatment for Human Immuno-deficiency Virus (HIV).

THIS CONSENT FOR RELEASE OR EXCHANGE OF INFORMATION HAS BEEN THOROUGHLY EXPLAINED TO ME. MY SIGNATURE IS GIVEN VOLUNTARILY AND INDICATES THAT I UNDERSTAND THE CONTENTS. All information released will be handled confidentially in compliance with the Mental Health Procedures Act, Confidentiality of HIV (AIDS) - Related Information ACT 148, Federal Alcohol and Drug Abuse Act, Pennsylvania Drug and Alcohol Abuse Control Act and Privacy Rule under HIPAA (1996), and the Family Educational Rights and Privacy Act (FERPA).

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Client Name | Chart Number:

Client's Signature (Parent/Guardian as appropriate)	*Date:*
Signature of Witness (required)	*Date:*

The following is to be used for verbal consent.

Note: Verbal consent must be obtained in person . T**wo** witnesses must be physically present and individually hear the Consent, then sign and date below.

Check if using verbal consent ☐	
Witness	*Date:*
Witness	*Date:*

The above client, being physically unable to provide a signature, has given verbal consent to release the information set forth herein to the undersigned witnesses who witnessed that the person understood the nature of the release and freely gave his/her verbal consent.

Reminders:

1. **For Behavioral Health Clients** (under age 14), Consent for Release of Information must be signed by one parent or a legal guardian. Signatures of stepparents are not valid. If parents are divorced, a parent having legal custody must sign.
2. **For Intellectual Developmental Disabilities Clients** (under age 18) Consent for Release of Information must be signed by one parent or a legal guardian. Signatures of stepparents are not valid. If parents are divorced, the parent having legal custody must sign.
3. Consent for Release of Information signed by a legally appointed guardian or representative must be accompanied by proof of eligibility (Photocopy of the legal document will be kept on file for future reference.)
4. Dated signatures of witnesses are required as stated above
5. Consent for Release of Information forms that are not signed and dated are invalid.
6. Copy of Consent for Release of Information should be included in case record.