



## Consent for Release or Exchange of Information

**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: SCO(08)

Date of Birth: \_\_\_\_\_

Chart Number: \_\_\_\_\_

**As an active participant in services at Westmoreland Casemanagement and Supports, Inc., I consent to the request for and the release of my records and/or exchange of information between the parties listed below. This consent includes the sharing of both verbal and written communication.**

**Westmoreland Casemanagement and Supports Inc.  
Attention: Privacy Officer  
134 Industrial Park Rd.  
Greensburg, PA 15601**

Provider Name: Regional Integrated Human Services (RIHS)

Address: 766 East Pittsburgh St.

City: Greensburg State: PA Zip Code: 15601

### Purpose of Request or Disclosure

- |  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> Referral for Service         | <input checked="" type="checkbox"/> Treatment Planning | <input checked="" type="checkbox"/> Insurance/Legal |
| <input checked="" type="checkbox"/> To Evaluate Need for Service | <input type="checkbox"/> Other                         |   |

### Specific Information Being Requested

- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> Outpatient/Inpatient Records | <input checked="" type="checkbox"/> Psychiatric/Psychological History | <input checked="" type="checkbox"/> Physical Health/Medical Records |
| <input checked="" type="checkbox"/> Education/IEP/Vocational     | <input type="checkbox"/> Other:                                       |   |

Specific Dates of Documents Being Requested: \_\_\_\_\_ Through \_\_\_\_\_

### Specific Information Being Disclosed

#### Behavioral Health

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Psychiatric/Psychological History | <input type="checkbox"/> Physical Health/Medical Records | <input type="checkbox"/> Education/IEP/Vocational |
| <input type="checkbox"/> Referral Packet                   | <input type="checkbox"/> Other                           |   |

Specify document(s): \_\_\_\_\_

### Intellectual Development Disabilities

- |   |   |  |
|---|---|--|
| <input checked="" type="checkbox"/> Referral Packet               | <input type="checkbox"/> Priority of Urgency of Need for Services Report (PUNS)           | <input checked="" type="checkbox"/> Support Intensity Scale Assessment (SIS) |
| <input checked="" type="checkbox"/> Individual Support Plan (ISP) | <input checked="" type="checkbox"/> Other Initial Eligibility and re-evaluation documents |  |

### Early Intervention

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Individual Family Service Plan (IFSP) | <input type="checkbox"/> Evaluation Report (ER) |  |
| <input type="checkbox"/> Doctor Authorization                  | <input type="checkbox"/> 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).

Client Name: \_\_\_\_\_

Chart Number: \_\_\_\_\_

_____	_____
Client's Signature (Parent/Guardian as appropriate)	Date/Time
_____	_____
Signature of Witness (required)	Date/Time
<b><i>The following is to be used for verbal consent.</i></b> <b>Note:</b> Verbal consent must be obtained in person. <b>Two</b> witnesses must be physically present and individually hear the Consent, then sign and date below.	
_____	_____
Witness	Date/Time
_____	_____
Witness	Date/Time
<i>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.</i>	
<b>Reminders:</b> <ol style="list-style-type: none"><li><b>For Behavioral Health Clients</b> (under age 14), Consent for Release 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.</li><li><b>For Intellectual Development Disabilities Clients</b> (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.</li><li>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)</li><li>Dated signatures of witnesses are required as stated above.</li><li>Consent for Release of Information forms that are not signed and dated are invalid.</li><li>Copy of Consent for Release of Information should be included in case record.</li></ol>	