

R.E.A.C.H.
Reaching Educational Achievements with Clinical Mental Health
1516 Tire Hill Road
Johnstown, PA 15905
Office: 814.479.4080 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
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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	____ Determining eligibility for benefits
____ Continuing appropriate treatment or program	____ Case review
____ Other (specify) _____	____ 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
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_____ Witness	_____ Date	_____ Person informed client of their rights	_____ Date
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____ Unable to sign therefore giving verbal consent to release information _____ (person giving verbal consent)

_____ Witness	_____ Date	_____ Witness	_____ Date
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Name:

DOB: