Unity Family Services, Inc.

57 S. 9th Street. Suite B Indiana, PA 15701 & 118 Market Street, Kittanning, PA 16201
Indiana Fax: 724-465-2088 / Kittanning Fax: (724) 919-8412
UFS, Inc. automated line: (724) 845-2978 or Toll Free 866-771-4488

AUTHORIZATION TO RELEASE AND/OR REQUEST CONFIDENTIAL CLIENT INFORMATION

CLIENT NAME:		DOB:		SS#:	
☒ AUTHORIZATION TO RELEASE INFORMATION AND PARTICIPATION REQUEST					
I, the undersigned, hereby give permission and consent to Unity Family Services Inc. to release pertinent information and/or grant participation in my treatment to:					
INFORMATION IS TO BE RELEASED TO:	Name/Organization:				
Address:		Phone:		Fax:	

CLIENT NAME:		DOB:		SS#:	
☒ AUTHORIZATION TO OBTAIN INFORMATION AND PARTICIPATION REQUEST					
I, the undersigned, hereby give permission and consent to Unity Family Services Inc. to release pertinent information and/or grant participation in my treatment to:					
INFORMATION IS TO BE RELEASED FROM:	Name/Organization:				
Address:		Phone:		Fax:	

PURPOSE/NEED FOR THE RELEASE OF THIS INFORMATION WILL BE USED FOR (CHECK ALL THAT APPLY)		
☒ COLLABORATION	☒ RESOURCE REFERRAL	☒ COORDINATION OF CARE
☐ TEAM MEETINGS/TX PLANNING	☒ LINKAGE PURPOSES	☒ DISCHARGE PLANNING
☒ ASSESSMENT	☒ INSURANCE/LEGAL PURPOSES	☐ OTHER:

SPECIFIC INFORMATION/RECORDS TO BE OBTAINED/RELEASED (CHECK ALL THAT APPLY): (INCLUDE DATES FOR RECORD REQUESTS)		
☒ OUTPATIENT RECORDS:		☒ INPATIENT RECORDS:
☐ SERVICE PLAN	☐ PROGRESS NOTES/REVIEWS	☒ VERBAL COMMUNICATIONS
☐ TREATMENT PLAN	☒ PSYCHOLOGICAL EVALUATIONS	☐ PHYSICAL EXAM (S) (MEDICATION HISTORY AND IMMUNIZATION RECORDS)
☒ PRESRIPTION FOR SERVICES	☐ POLICE/HOUSING/LEGAL RECORDS	☐ SCHOOL RECORDS (GRADES, ATTENDANCE, IEP, CONDUCT AND COUNSELING)
☐ VOCATIONAL TESTING RESULTS	☒ DISCHARGE SUMMARY	☐ PEER SUPPORT/THERAPEUTIC DOCUMENTATION
☒ EVALUATIONS	☒ INTAKE M/H ASSESSMENT	☐ OTHER:

METHOD OF RELEASE (MUST CHECK ONE):	☐ VERBAL ONLY	☐ WRITTEN ONLY	☒ VERBAL AND WRITTEN

PEER'S CONSENT: THIS CONSENT SHALL BE IN EFFECT UNTIL Exp. Date OR 90 DAYS AFTER DISCHARGE FROM THE PROGRAM.

I have been told that to protect the limited confidentiality of records, my agreement to obtain tor release information is necessary and that the permission is limited for the purposes and to the person/agency listed above. I understand that I may my permission at any time in writing except for action that has already been taken. This right and other rights are contained within the HIPAA privacy notice. I acknowledge and understand that treatment is not conditioned upon my signing of this authorization. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this subpart. I understand that I may ask to see information that is sent. I also understand that the information to be released could include HIV-related information and drug and alcohol-related information if contained in these records. THIS CONSENT FOR RELEASE 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 of 1966; Confidentiality of HIV - AIDS Related Information Act 148; Federal Alcohol and Drug Abuse Act; PA Drug and Alcohol Abuse Act; Privacy Rule under HIPAA 1996; and, the Family Educational Rights and Privacy Act (FERPA).

PEER SIGNATURE DATE SIGNATURE OF WITNESS (REQUIRED) DATE

UOC PEER SPECIALIST SUPERVISOR DATE (PRINT) NAME OF WITNESS OBTAINING CONSENT DATE