EMOTIONAL WELLNESS LLC (emwell.org)
3933 Perkiomen Avenue, Suite 101 * Reading, PA 19606
2481 Lancaster Pike, Shillington, PA 19607
(PH) 610-779-7272 * (FAX) 610-985-9100

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _________________________________, do hereby consent and authorize Emotional Wellness LLC to disclose to **Exeter Township School District** the following information from my record(s):

___ Initial Assessment ___ Admission/Attendance ___Progress in Treatment
___ Medical History ___ Prognosis/Diagnosis ___ Discharge Summary
___ Treatment Plan ___ Other _______________________________________

The purpose of this disclosure is to:
___ Coordinate treatment with __ family, __ other involved agencies, __ referral source
___ Secure/provide ongoing treatment ___ Other ____________________________

X__________________________________ ___________________________________
Client Signature Date Parent/Guardian Signature Date

____
Witness Signature Date

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Law 93-282, and/or Code of Federal Regulations, 42 (Drug and Alcohol Treatment records). I understand that I have the right to request to inspect materials that shall be released. I understand that I may revoke this authorization at any time by notifying Emotional Wellness LLC in writing. This authorization shall expire six (6) months after discharge from treatment unless otherwise specified ______________________________. Federal regulation prohibits receiver from making further disclosure without specific written consent. I understand I am entitled to a copy of this document in its completed form. ___ Accepted or ___ Refused Copy of Release of Information.

I, _________________________________, do hereby consent and authorize Emotional Wellness LLC to receive from **Exeter Township School District** following information from my record(s):

___ Initial Assessment ___ Admission/Attendance ___Progress in Treatment
___ Medical History ___ Prognosis/Diagnosis ___ Discharge Summary
___ Psychiatric Evaluation ___ Social History
___ Treatment Plan ___ Other _______________________________________

The purpose of this disclosure is to:
___ Coordinate treatment with __ family, __ other involved agencies, __ referral source
___ Secure/provide ongoing treatment ___ Other ____________________________

X__________________________________ ___________________________________
Client Signature Date **Client's Date of Birth**

__________________________________ ___________________________________
Witness Signature Date Parent/Guardian Signature Date