

EMOTIONAL WELLNESS LLC (emwell.org)

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby consent and authorize Emotional Wellness LLC to disclose to _____ 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 _____ the 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 Date of Birth**

 Witness Signature Date Parent/Guardian Signature Date