**Consent for Release of Information**

**Project SILK**

810 Penn Avenue, 8th Floor

Pittsburgh, PA 15222

(412) 532-2123

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **I,** |  | **born on**  |  | **hereby authorize** |
|  | ***(name of person releasing information)*** |  | ***(date of birth)*** |  |
|  |
| ***(Name and address of person, agency, or facility releasing information)*** |
|  |
| **To release information to:** |
|  |
| ***(Name and address of person, agency, or facility information is being released to)*** |
| **For the purpose of:**  |
|  |
|  |

The information to be released includes information from the organization’s records relating to my identity, prognosis and/or treatment which may include information relating to psychological or psychiatric disorders, medical conditions, and drug and/or alcohol use. The specific documents to be disclosed include:

|  |  |  |
| --- | --- | --- |
| [ ]  Psychiatric Evaluations | [ ]  Social History | [ ]  Case Notes |
| [ ]  Medical History | [ ]  Lab Reports | [ ]  Family Service Plan |
| [ ]  Medications | [ ]  Psychological tests | [ ]  Utility History |
| [ ]  Discharge Summaries | [ ]  Intake Assessments | [ ]  Written Sharing of Information |
| [ ]  Treatment Recommendations | [ ]  History of hospitalizations  | [ ]  Other: |  |
| [ ]  Verbal Sharing of Information | [ ]  Credit Reports | [ ]  Other: |  |
| [ ]  Criminal Record Check | [ ]  Rent Ledger | [ ]  Other: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **For Range of Services from:** |  | to |  |

|  |  |
| --- | --- |
| **Please forward information to:**  |  |
|  |
|  |

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited to the employees of the program. I understand that this authorization may be revoked at any time simply by notifying Community Human Services in writing, except for any action that has already been taken.

I also understand that this authorization shall be in effect 365 days from the date signed. I certify that I have read and fully understand the foregoing statements.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature of Consumer:** |  | **Date:** |  |
| **Signature of Witness:**  |  | **Date:** |  |

**Note: Photocopies of this form will be considered valid.**