

Dear Parents,

Please review and sign the following releases of information.

These are included in order for us to coordinate with Easton Coach to provide transportation and other necessary agencies for your child to attend the Summer Therapeutic Activities Program.

If your child is over 14 years old, he/she would also need to sign these releases of information under "Signature of Client (14 years of age and older)"

If you have any questions please contact:

Adrienne Billmyer Clinical Supervisor billmyera@elwyn.org 610-573-2512

or

Shane McCaslin
Case Manager
mccaslins@elwyn.org
610-573-2505

We are looking forward to another great summer; Please do not hesitate to contact us if you have any questions!

I, _ (Da	, authorize the following disclosu ate of Birth), Protected Health Info	re(s) of my/my child's (if under 14 years of age), rmation ("PHI"):	
	ese records are needed for the purpose of (please in ent's request, other: <u>Coordination of care</u>	ndicate): Admission, Evaluation, Treatment, Clinical File Audit, at	
<u>X</u> _X	e following information from the records of the about Treatment/Discharge Summary Psychiatric Evaluation Psychiatric History Medical Records (specify): X_ Developmental History her (list specific documents and dates): Verbal com	_X Psychological Evaluation Neurological Examination Social Service Summary X Physician's Orders School Records	
1. 2.	The Covered Entity releasing/disclosing the PHI is: The individual or entity receiving the PHI is: Mage	•	
3.	. I understand that the information disclosed pursuant to this Authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient.		
4.	I. I understand that I have the right to revoke this Authorization in writing at any time by sending a letter to Elwyn's Privacy Officer at 111 Elwyn Road, Elwyn, Pennsylvania 19063. The effective date of my revocation will be the date the Privacy Officer receives it. I further understand that any revocation will be effective only to the extent that the Covered Entity has not already taken action in reliance on this Authorization.		
5.		obtained as a condition of obtaining insurance coverage and I s the insurer with the right to contest a claim under the policy or	
6.	I understand that Elwyn is not conditioning my tre whether I agree to sign this Authorization.	eatment, payment, enrollment, or eligibility for benefits on	
7.	This Authorization shall expire on	(not to exceed 1 year from date of signature)	
Sig	nature of Client (14 years of age and older)	Date	
 Sig	nature of Parent/Guardian	 Date	
— Sig	nature of Witness	 Date	
— Na	me of personal representative (if applicable) and re	elationship (description of authority to act)	

I,, author (Date of Birth)	ize the following disclosure , Protected Health Infor	e(s) of my/my child's (if under mation ("PHI"):	14 years of age),
These records are needed fo client's request, other: <u>Coo</u>		dicate): Admission, Evaluatior	n, Treatment, Clinical File Audit, at
_		/e named person, are requeste	ed:
X Treatment/Discharge SPsychiatric Evaluation		X Psychological Evaluation Neurological Examination	
Psychiatric History	_	Social Service Summary	
Medical Records (specify	/): 	Physician's Orders	
Developmental History		, School Records	
Other (list specific document	s and dates): <u>Verbal comn</u>	<u>munication</u>	
	sing/disclosing the PHI is: E		
2. The individual or entity r	eceiving the PHI is: County	:	
	3. I understand that the information disclosed pursuant to this Authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient.		
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			nining insurance coverage and I ontest a claim under the policy or
6. I understand that Elwyn whether I agree to sign t		atment, payment, enrollment,	or eligibility for benefits on
7. This Authorization shall e	expire on	(not to exceed 1 year f	rom date of signature)
Signature of Client (14 years	of age and older)	Date	-
Signature of Parent/Guardia	n	Date	-
		Date	_
			-
Name of personal representa	ative (if applicable) and rela	ationship (description of autho	ority to act)

(Date of Birth), authorize the following disclos	formation ("PHI"):		
These records are needed for the purpose of <i>(please</i> client's request, other: <u>Coordination of care</u>	indicate): Admission, Evaluation, Treatment, Clinical File Audit, at		
The following information from the records of the abX Treatment/Discharge Summary Psychiatric Evaluation	oove named person, are requested: Psychological Evaluation Neurological Examination		
Psychiatric History Medical Records (specify):	Social Service Summary Physician's Orders		
Developmental History Other (list specific documents and dates): Verbal con	School Records		
 The Covered Entity releasing/disclosing the PHI is The individual or entity receiving the PHI is: Scho 	·		
·	 I understand that the information disclosed pursuant to this Authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient. 		
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. I further understand that if this Authorization was obtained as a condition of obtaining insurance coverage and I revoke this Authorization, then other law provides the insurer with the right to contest a claim under the policy or the policy itself.			
6. I understand that Elwyn is not conditioning my tr whether I agree to sign this Authorization.	reatment, payment, enrollment, or eligibility for benefits on		
7. This Authorization shall expire on	(not to exceed 1 year from date of signature)		
Signature of Client (14 years of age and older)	Date		
Signature of Parent/Guardian	 Date		
Signature of Witness	 Date		
Name of personal representative (if applicable) and r	relationship (description of authority to act)		

(Date of Birth), Protected Health Information ("PHI"): These records are needed for the purpose of (please indicate): Admission, Evaluation, Treatment, Clinical File Audit, at client's request, other:		
The following information from the records of the above named person, are requested: X Treatment/Discharge Summary		
X Treatment/Discharge Summary — Psychological Evaluation — Psychiatric Evaluation — Neurological Examination — Psychiatric History — Social Service Summary — Medical Records (specify): — — Physician's Orders — Developmental History — School Records Other (list specific documents and dates): Verbal communication, notification of service 1. The Covered Entity releasing/disclosing the PHI is: Elwyn. 2. The individual or entity receiving the PHI is: Primary Care Physician: —— 3. I understand that the information disclosed pursuant to this Authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient. 4. I understand that I have the right to revoke this Authorization in writing at any time by sending a letter to Elwyn's Privacy Officer at 111 Elwyn Road, Elwyn, Pennsylvania 19063. The effective date of my revocation will be the date the Privacy Officer receives it. I further understand that any revocation will be effective only to the extent that the		
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6. I understand that Elwyn is not conditioning my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this Authorization.		
7. This Authorization shall expire on (not to exceed 1 year from date of signature)		
Signature of Client (14 years of age and older) Date		
Signature of Parent/Guardian Date		
Signature of Witness Date		
Name of personal representative (if applicable) and relationship (description of authority to act)		

I, _ (Da	, authorize the following disclosur ate of Birth), Protected Health Info	re(s) of my/my child's (if under 14 years of age), rmation ("PHI"):	
	ese records are needed for the purpose of (please in ent's request, other: <u>Coordination of care</u>	ndicate): Admission, Evaluation, Treatment, Clinical File Audit, at	
_X		Psychological Evaluation Neurological Examination Social Service Summary Physician's Orders School Records	
1. 2.	The Covered Entity releasing/disclosing the PHI is: The individual or entity receiving the PHI is: Private	•	
3.	I understand that the information disclosed pursua federal health privacy rule and may be subject to r	ant to this Authorization may no longer be protected by the re-disclosure by the recipient.	
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	e following information from the records of the abo		
		_X Psychological Evaluation Neurological Examination	
	Psychiatric History	Social Service Summary	
	x_ Medical Records (specify):		
	, , ,	School Records	
Ot	her (list specific documents and dates): Verbal com	munication.	
	The Covered Entity releasing/disclosing the PHI is:		
2.	The individual or entity receiving the PHI is: Paren	t/guardian:	
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<u>X</u>	Treatment/Discharge Summary	Psychological Evaluation	
	_ Psychiatric Evaluation _ Psychiatric History	Neurological Examination Social Service Summary	
	_ Psychiatric History _ Medical Records (specify):	Social Service Summary Physician's Orders	
	Developmental History	School Records	
Otl	her (list specific documents and dates): Verbal com		
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Sig	nature of Client (14 years of age and older)	Date	
 Sig	nature of Parent/Guardian	 Date	
	nature of Witness		
Sig	nature of Witness	Date	
Na	me of personal representative (if applicable) and re	elationship (description of authority to act)	