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!

ELWYN
HIPAA AUTHORIZATION

I, __ ______________, authorize the following disclosure(s) of my/my child's (if under 14 years of age)__ ___________, (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: _Coordination of care_

The following information from the records of the above named person, are requested:

_X_ Treatment/Discharge Summary
_X_ Psychiatric Evaluation
___ Psychiatric History
___ Medical Records (specify): ________________
_X_ Developmental History
_X_ Psychological Evaluation
___ Neurological Examination
___ Social Service Summary
_X_ Physician's Orders
___School Records

Other (list specific documents and dates): Verbal communication

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1. The Covered Entity releasing/disclosing the PHI is: Elwyn.
2. The individual or entity receiving the PHI is: Magellan Behavioral Health of PA.
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 Covered Entity has not already taken action in reliance on this Authorization.
5. 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 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)

ELWYN
HIPAA AUTHORIZATION

I, __ _____________, authorize the following disclosure(s) of my/my child's (if under 14 years of age)__ __________, (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: Coordination of care

The following information from the records of the above named person, are requested:

_X__ Treatment/Discharge Summary
___ Psychiatric Evaluation
___ Psychiatric History
___ Medical Records (specify): _______________
___ Developmental History
_X__ Psychological Evaluation
___ Neurological Examination
___ Social Service Summary
___ Physician's Orders
___School Records

Other (list specific documents and dates): Verbal communication

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1. The Covered Entity releasing/disclosing the PHI is: Elwyn.
2. The individual or entity receiving 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.

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 Covered Entity has not already taken action in reliance on this Authorization.

5. 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 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)

ELWYN
HIPAA AUTHORIZATION

I, __ ______________, authorize the following disclosure(s) of my/my child's (if under 14 years of age)__ ___________, (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: _Coordination of care_

The following information from the records of the above named person, are requested:

_X_ Treatment/Discharge Summary
___ Psychiatric Evaluation
___ Psychiatric History
___ Medical Records (specify): ________________
___ Developmental History
___ Psychological Evaluation
___ Neurological Examination
___ Social Service Summary
___ Physician's Orders
___School Records

Other (list specific documents and dates): Verbal communication

1. The Covered Entity releasing/disclosing the PHI is: Elwyn.
2. The individual or entity receiving the PHI is: School:

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 Covered Entity has not already taken action in reliance on this Authorization.

5. 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 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)

ELWYN
HIPAA AUTHORIZATION

I, __ _____________, authorize the following disclosure(s) of my/my child's (if under 14 years of age)__ __________, (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: _Coordination of care____

The following information from the records of the above named person, are requested:

_X__ Treatment/Discharge Summary
___ Psychiatric Evaluation
___ Psychiatric History
___ Medical Records (specify): _______________
___ Developmental History
___ Psychological Evaluation
___ Neurological Examination
___ Social Service Summary
___ Physician's Orders
___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 Covered Entity has not already taken action in reliance on this Authorization.
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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)

ELWYN
HIPAA AUTHORIZATION

I, __ _____________, authorize the following disclosure(s) of my/my child's (if under 14 years of age)__ __________, (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: Coordination of care

The following information from the records of the above named person, are requested:

_X__ Treatment/Discharge Summary
___ Psychiatric Evaluation
___ Psychiatric History
__x_ Medical Records (specify): _______________
___ Developmental History
___ Psychological Evaluation
___ Neurological Examination
___ Social Service Summary
___ Physician's Orders
___School Records

Other (list specific documents and dates): Verbal communication, benefit verification.

1. The Covered Entity releasing/disclosing the PHI is: Elwyn.
2. The individual or entity receiving the PHI is: Private Insurance Carrier: ____________________________________
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 Covered Entity has not already taken action in reliance on this Authorization.
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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)

ELWYN
HIPAA AUTHORIZATION

I, __ _____________, authorize the following disclosure(s) of my/my child's (if under 14 years of age)__ __________, (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: Coordination of care

The following information from the records of the above named person, are requested:

_X__ Treatment/Discharge Summary
_X__ Psychiatric Evaluation
___ Psychiatric History
__x_ Medical Records (specify): _______________
___ Developmental History
_X__ Psychological Evaluation
___ Neurological Examination
___ Social Service Summary
_X__ Physician's Orders
___School Records

Other (list specific documents and dates): Verbal communication.

1. The Covered Entity releasing/disclosing the PHI is: Elwyn.
2. The individual or entity receiving the PHI is: Parent/guardian: ___________________________________
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 Covered Entity has not already taken action in reliance on this Authorization.
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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)

ELWYN
HIPAA AUTHORIZATION

I, __ ______________, authorize the following disclosure(s) of my/my child's (if under 14 years of age)__ ___________,
(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: _Coordination of care____

The following information from the records of the above named person, are requested:

_X__ Treatment/Discharge Summary
___ Psychiatric Evaluation
___ Psychiatric History
___ Medical Records (specify): ________________
___ Developmental History
___ Psychological Evaluation
___ Neurological Examination
___ Social Service Summary
___ Physician's Orders
___School Records

Other (list specific documents and dates): Verbal communication.

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1. The Covered Entity releasing/disclosing the PHI is: Elwyn.
2. The individual or entity receiving the PHI is: Easton Coach
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 Covered Entity has not already taken action in reliance on this Authorization.
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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)