

Intercommunity Action, Inc.
PCP Release TO Interact v2

Client: Test, Test **DOB:** 10/06/1987 **Gender:** Female **ID#** 00000001 **Intake:** 05/04/2015 05:00am

Client: _____

Event: _____

Actual Date: _____

Staff: _____

Uploaded Document: No document attached

No PCP or Client Refused to Sign: _____

Release Information To:

:

I hereby authorize confidential information to be released from my/the client's clinical records pertaining to my/the client's evaluation and treatment:

TO:
Person: Medical Records
Organization: Interact
Address: 6122 Ridge Avenue, Philadelphia, PA 19128
Phone#: 215-487-1330 or FAX 215-487-1641

Release Information From:

PCP Contact Information:

Organization Practitioner Type Frequency of Interactions Other Frequency Information

:

These records are required for the specific purpose of coordinating:

Coordination of Care Referral Evaluation Treatment Services Other

--If Other, please specify

Information to be released from my records covers the time period starting at this date:

To this date:

Information to be released from my records is limited to: (check all that apply)

Current Status Diagnosis Medications Personal and family history of hypertension, diabetes, dyslipidemia, hypertension or cardiovascular disease Weight and height Waist circumference Blood Pressure Most recent Lipid Panel Progress Summary

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Summary Other

If Other was checked, please specify below:

This consent shall be effective from this date:

To this date:

(NOT TO EXCEED ONE YEAR)

I have been informed that I may revoke this authorization at any time by oral or written request to the Behavioral Health Division at Intercommunity Action, Inc. (except to the extent that action has been taken in reliance on this authorization). I have also been informed of my rights to inspect materials to be released (subject to Section 7100.111.3 of the Pennsylvania Mental Health Procedures Act and/or subject to the Pennsylvania Drug and Alcohol Control Act), and that disclosure relating to drug or alcohol abuse or dependency is pursuant to applicable state and federal laws and regulations. Disclosure is also limited to comply with the Confidentiality of HIV-Related Information Act, 1991. Further, I understand that, despite all care taken, information transmitted electronically (faxed) is occasionally received by a party not intended to be the recipient; I release Intercommunity Action, Inc. from all liability should this occur.

I certify that this form has been fully explained to me and that I understand its contents.

Client Signature/Date (or guardian if MH under 14): _____

Witness Signature/Date: _____

To Be Completed and Signed by Two Witnesses if Client is Unable to Sign

Acknowledgement: _____

Signature of Witness of Person Unable to Sign/Date: _____

Signature of Witness of Person Unable to Sign/Date: _____

Client accepts a copy of this Release form: _____

Client does not want a copy of this Release form: _____

Service Related Encounter Information

Exempt from Billing: _____

Activity Type: _____

Client Involved: _____

Program Providing Service: _____

Facility Providing Service: _____

Encounter With: _____

Service Authorization: _____

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Next Event Due: _____

Next Scheduled Event
