CASSP AUTHORIZATION FOR RELEASE OF INFORMATION

200 East St. Williamsport, PA 17701 . (570) 326-7895 ext. 9241

I authorize the use/disclosure of information about me (or my child/adolescent if under age 14) as described below:

Member: ________________________________ Date of Birth: _____________ MAID #_________________

I authorize Lycoming-Clinton Joinder CASSP Program to release and/or exchange protected health information to the following:

Agencies / Providers / Services – * Read second page for full list of specific provider / agency names*

- _________________________________Children and Youth
- _________________________________ County Probation
- School District (*specify*)____________________________
- Lycoming-Clinton CASSP
- Lycoming/Clinton MH/ID
- Community Care Behavioral Health (CCBH)
- BLaST IU 17 (Lycoming Intermediate Unit)
- Central IU 10 (Clinton Intermediate Unit)
- Psychiatric Inpatient Hospitalization Providers ____
- School Based Behavior Health (CSBBH / MH SBOP) ____
- Referring Agency (*specify*)__________________________
- Other (*specify*)________________________________
- Other (*specify*)________________________________
- Other (*specify*)________________________________

- Primary Physician (PCP) _______________________
- Psychiatry ___________________________________
- West Branch Drug and Alcohol Commission
- Early Intervention
- Outpatient Services:__________________________
- FBMHS Provider______________________________
- IBHS Provider_________________________________
- Partial Hospitalization Program Providers ____
- Home Health Care Providers ____
- Out of Home Placements ____
- Parent (*14 or older*)___________________________
- Parent (*14 or older*)___________________________
- Other (*specify*)_______________________________
- Other (*specify*)_______________________________

INFORMATION TO BE DISCLOSED:

This information has been disclosed to you from records whose CONFIDENTIALITY is protected by State Law. Pennsylvania State Regulations prohibit you from making any further disclosure of this information without the prior written consent of person with respect to whom it pertains. ***Revised 01/22/2020***

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- Psychological Evaluation
- Social History
- Drug and Alcohol History
- Insurance Information
- Behavior Reports
- Psychosocial History
- Medical History/Records
- Progress Reports
- School Feedback/Reports
- School Records
- Psychiatric Evaluation
- CASSP Referral/Service Plan
- Discharge Summary
- Treatment Plans
- Other:______________________

REVOCATION: I understand that I may revoke this authorization in writing at any time by sending written notification to the provider. I understand that any such revocation is

not effective to the extent that action has been taken in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law. I understand that providing authorization for the requested use or disclosure is not a condition of my treatment, payment, enrollment in a health plan or eligibility for benefits except (1) if my treatment is related to research; or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

This authorization shall be in force and effect until _________________________. (Note: must specify an expiration date such as one year from today's date)

SPECIAL AUTHORIZATION: My (or my youth's) evaluation, diagnosis, and/or treatment may be released to the requestor(s) noted above as indicated by *my initials* next to the information to be released.
[   ] Behavioral Health   [   ]HIV/AIDS   [   ]Alcohol and/or drug abuse or dependence

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AUTHORIZATION: I authorize the provider to release the information above to the requestor.

Youth Signature (*required if age 14 +*): ____ Date: __________________________

Parent / Representative Signature: ____ Date: __________________________

Witness Signature (referral source): ____ Date: __________________________

IF CONSUMER IS UNABLE TO CONSENT BECAUSE OF AGE OR PHYSICAL CONDITION, PLEASE COMPLETE ONE OF THE FOLLOWING:
Consumer (is a minor ___ years of age) OR is unable to give consent because
____

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