Avers & Biddle Counseling Associates LLC
1681 Crown Avenue Suite 10 Lancaster, PA 17601
PHONE (717) 208-6686 FAX (717) 208-6687

Authorization For Release Of Information

This document should be completed if you would like your therapist to collaborate and share information with anyone outside of this organization. That may include a family member, a primary care doctor, a previous therapist, a child's school, etc.

Client Name: _____ Date of Birth: _____

I do hereby consent and authorize Avers & Biddle Counseling Associates LLC to receive from and/or disclose information to:

Name:_____

Address:_____

Phone Number:_____

Information Authorized To Be Released:

- ☐ Attendance and participation in treatment
- ☐ General treatment status, goals, and or progress
- ☐ Treatment plan document
- ☐ Intake and or discharge summaries
- ☐ Assessment results and diagnoses
- ☐ Care coordination and treatment recommendations
- ☐ Safety concerns and safety planning
- ☐ Billing records
- ☐ Other

_____

_____

This Information Will Be Used For The Purpose Of:

- ☐ Coordination of treatment
- ☐ Referral
- ☐ Discharge Planning
- ☐ Treatment Planning
- ☐ Other:

_____

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Authorization for Disclosure of HIV-Related Information

The Pennsylvania Confidentiality of HIV-Related Information Act, 35 P.S. §§ 7601–7611, including § 7607, requires specific written consent to disclose HIV-related information. This section lets you choose whether that information may be shared with the person or organization named on this form.

☐ **Yes.** I specifically authorize Avers & Biddle Counseling Associates LLC and the person or organization named on this form to disclose HIV-related information, including information about HIV-related testing or HIV status, to one another for the purpose and duration selected on this form.
☐ **No.** I do not authorize disclosure of HIV-related information.

Notice required by Pennsylvania law to accompany each disclosure made with written consent:
This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act, 35 P.S. §§ 7601–7611. A general authorization for the release of medical or other information is not sufficient for this purpose.

Authorization for Disclosure of Drug and Alcohol Treatment Information

Certain substance use disorder records may have additional confidentiality protections under federal law (42 CFR Part 2) and Pennsylvania law (Drug and Alcohol Abuse Control Act, 71 P.S. § 1690.108, as amended by Act 33 of 2022). This section lets you authorize disclosure of those records when these protections apply.

☐ **Yes.** I specifically authorize Avers & Biddle Counseling Associates LLC and the person or organization named on this form to disclose to one another information related to my substance use disorder diagnosis, treatment, or referral for treatment, as selected on this form, for the purpose and duration stated on this form.
☐ **No.** I do not authorize disclosure of this information.

I understand that I may revoke this authorization in writing, except to the extent action has already been taken in reliance on it.

Notice to accompany each disclosure of records protected by 42 CFR Part 2:
42 CFR part 2 prohibits unauthorized use or disclosure of these records. A copy of this authorization or a clear explanation of its scope must accompany each disclosure.

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Notice To The Individual Giving This Authorization

1. Signing this authorization is voluntary. Avers & Biddle Counseling Associates will not condition your treatment on signing it.
2. You may revoke this authorization in writing at any time. Revocation will not apply to information already disclosed or actions already taken in reliance on this authorization.
3. Information disclosed to the person or organization named on this form may be shared again by that recipient and may no longer be protected by federal privacy law. Other laws may still apply.

I understand this authorization is effective immediately and will expire:

- ☐ Upon Discharge
- ☐ Other: _____

_____

Client Name - Relationship to Client Client Signature Date

_____

Witness Name Witness Signature Date