GLADE RUN LUTHERAN SERVICES
a bridge to a brighter future through lifelong learning

Zelienople Campus	Beaver Falls Office	Butler Office	Cranberry Office	Pittsburgh Office
P.O. Box 70	Beaver Falls Plaza, Ste. 210	220 S. Main Street, Ste. B	8001 Rowan Rd,	5648 Friendship Ave.
Zelienople, PA 16063	1008 Seventh Avenue	Butler, PA 16001	Ste. 212	2nd and 3rd Floor
(724) 452-4453	Beaver Falls, PA 15010	(724) 283-9436	Cranberry Twp., PA 16066	Pittsburgh, PA 15206
1-800-371-0545	(724) 843-0816	1-877-328-8537	(724) 591-8102	(412) 661-1827
FAX: (724) 452-6576	FAX: (724) 843-0818	FAX: (724) 282-9759	FAX (724) 591-8104	FAX: (412) 661-1867

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

All parts of this authorization must be completed in compliance with the Pennsylvania Mental Health Procedures Act and the Pennsylvania and Federal Regulations concerning confidentiality of mental health, health care, HIV, and alcohol and drug abuse records.

Client Name: _____ **Date of Birth:** _____

Social Security #: _____

I authorize Glade Run Lutheran Services to: ☐ request information from ☐ release information to ☐ or verbally communicate with the following:

Name of Facility: _____

Address: _____

_____

_____

Telephone: _____ **FAX:** _____

If records are being requested, please send/fax to the appropriate address/fax # listed above.

☐ Beaver Falls ☐ Pittsburgh ☐ Cranberry

☐ Butler ☐ Zelienople

The information regarding my treatment records is for the purpose of _____ and covers records for the time period beginning _____ through _____

INFORMATION TO BE DISCLOSED

Mental Health Information		Physical Health and Other Information	
___ Social/Family History	___ Teacher/Counselor Observations	___ Medical History	___ Teacher/Counselor Observations
___ Psychiatric/Psychological Evaluation	___ Treatment Plan	___ Laboratory Tests	___ Treatment Plan
___ Psychological/Educational Testing	___ Treatment Reviews	___ Discharge Summaries	___ Treatment Reviews
___ Discharge Summaries	___ Permission to FAX Records	___ Other: _____	___ Other: _____
___ Other: _____	___ Permission for Verbal Exchange		

I understand that this authorization is subject to revocation at any time, at my written request, except to the extent that the program making the disclosure, has already taken action in reliance on it. The Medical Records Department may be contacted to get a copy of the Revocation of Consent and/or Authorization Form.

I understand that information used or disclosed under this Authorization could potentially be redisclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.

I understand that Glade Run Lutheran Services may not require that I sign this Authorization in order to obtain treatment.

I have read this form, and it has been explained to me. I understand its contents.

_____ _____

(Signature of Client or Parent/Guardian if Client under 14) (Date of Signature)

_____ _____

(Signature of Witness) (Date of Signature)

This authorization shall be in effect for one (1) year from this date:

VERBAL CONSENT

(For Persons Physically Unable to Provide a Signature)

Verbal consent requires two (2) written signatures. I witnessed that the person named above understood the nature of this release and freely gave his/her verbal consent to initiate this request as indicated above.

_____ _____

(Signature of Client/Parent/Guardian) (Date of Signature)

_____ _____

(Signature of Witness) (Date of Signature)