INDEPENDENT EDUCATIONAL EVALUATORS OF AMERICA, LLC

AUTHORIZATION TO OBTAIN INFORMATION

I do hereby consent and authorize _____to disclose to:

Name:	Independent Educational Evaluators of America, LLC
Address:	1555 Highlands Drive, Suite 103, Lititz, PA 17543
Phone Number:	(717-569-6223
Fax Number:	(717-560-9931

Information from my record(s) related to my identity, diagnosis, prognosis and treatment (including diagnosis and/or treatment for mental health, drug/alcohol abuse and/or HIV-related information). The specific information to be received / disclosed includes: (Please mark an X for each document.)

_____Discharge Summary
_____Special History
_____Medical Record
_____History and Physical
_____Outpatient Treatment Summary
_____Discharge Instructions
_____Alcohol and Other Drug Consult
_____Progress Notes
_____Any and all Records
_____Other (list specific items): _____

_____Initial Evaluation/Admission Note
_____Psychological Evaluation/Summary
_____Homebound Instruction Report
_____Patient Data Form
_____Referral/Treatment Summary
_____Psychiatric Evaluation/Summary
_____Laboratory Reports
_____Medication Sheets

I understand this information is to be used for the purpose of: (check as many as apply) ☐ Diagnosis ☐ Continuity of Care ☐ Treatment Planning ☐ Discharge Planning ☐ Further Evaluation ☐ Other

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Public Law 93-282, and/or Code of Federal Regulations, 42 (Drug and Alcohol treatment records), and/or Act 148 (Confidentiality of HIV-related Information Act). I understand the nature of this release and understand that I have the right to inspect material that is to be released. I understand that I may revoke this authorization at any time by notifying Margaret J. Kay, Psychologist. This authorization shall be effective immediately and shall expire in one year from the date hereof or on _____ and is valid for all record documentation during the effective period.

I understand that I have the right to request a copy of this authorization and that I may revoke my consent at anytime by written notice. Check one: ☐ Patient accepted copy ☐ Patient declined copy

_____	_____	_____	_____
PATIENT'S SIGNATURE	DATE	RELATIONSHIP TO PATIENT	WITNESS

THIS PORTION TO BE COMPLETED WHEN PATIENT IS UNABLE TO GIVE WRITTEN CONSENT

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the above information. The patient has also been informed that he/she may verbally revoke this authorization at any time.

_____ Signature of Witness/Date

_____ Signature of Witness/Date

PATIENT NAME: _____ DATE OF BIRTH: _____