Family Service Association of Bucks County
Administrative and Privacy Offices
4 Cornerstone Drive, Langhorne, PA 19047
215.757.6916 (p) 215.757.2115 (f)

School-Based Outpatient Release
Children Ages 13 and Younger

D&A, MH, or HIV-related Information cannot be used/disclosed in reliance on this form unless specified explicitly as such under Item 2. D&A and HIV- related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION [SEND/RECEIVE]

I, ___________________________, parent/guardian of ___________________________, authorize **Family Service Association of Bucks County (Family Service)** to use and/or disclose my protected health information only as described below:

1. This Authorization's **purpose** is as follows: *Coordination of care with school staff* (school counselor/social worker, administrators, teachers, nurse)

2. This Authorization **covers** the following information about me:
   Treatment plan, crisis support plan, dates of treatment, special concerns ________________________________

3. This Authorization **permits** Family Service to release the covered information which it has in its possession. Family Service may release this information to the following person(s) or entity(ies):
   Name: ____
   Full Mailing Address:
   (Street, City, State, Zip Code) ____

4. This Authorization **permits** the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to Family Service immediately upon Family Service's request.

5. I understand that I have a **right to revoke** this Authorization at any time. I may revoke the authorization verbally or in written notification to Family Service. I understand that Family Service has a notification form for me to use if I wish to revoke this Authorization at any time before it expires. Revocation will be effective immediately upon Family Service's receipt of proper notification. I may not revoke this Authorization to the extent that Family Service has already relied upon it or if it was signed as a condition of obtaining insurance coverage.

6. In the absence of revocation, this Authorization **becomes effective** on *(Specify Date)* _________________ and **will expire** on (*Specify Date)* ____

7. Family Service is instructed to prohibit **re-disclosure** by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

8. I understand that Family Service may not require that I sign this Authorization in order to obtain treatment.

I have read this Authorization, or had it explained to me, and I understand its contents.
Family Service has given me a copy of this Authorization. Copy: ❑ Accepted ❑ Declined

Client's Signature ______________________________ **Date in Client's Handwriting** ____________________

Witness' Signature ______________________________ **Date in Witness' Handwriting** ____________________

VERBAL CONSENT: *(For use by persons unable to provide a signature.)* I have witnessed that the person giving Authorization understood the nature of this Authorization and freely gave his/her verbal consent. *(Two witnesses required.)*

/s/ **Witness 1** ___________________________________ /s/ **Witness 2** ___________________________________

Date in Witness' Handwriting ____________________ **Date in Witness' Handwriting** ____________________