25 East North Street
Carlisle, PA 17013
Ph (717) 422-6440
Fax (717) 620-0536

I ______________________________ with the Date of Birth ______/______/______
Client's Name   Month   Day   Year

authorize **Campbell Psychological Services** to exchange information from my record(s) and care, verbally or in writing, as described in Sections I and II below, with the following individual or entity:

Person or Entity: Big Spring School District

Address: 45 Mount Rock Road, Newville, PA 17241

Phone: (717) 776-2000   Fax: ______________________

I: Campbell Psychological Services may release the following information to the party listed above:

- ☑ Attendance in treatment
- ☐ Intake Summary
- ☐ Treatment Plan & Recommendations
- ☐ Progress Notes
- ☐ Evaluation and/or Assessment results, including written report
- ☐ Treatment Summary & Progress
- ☐ Discharge Summary
- ☑ Other: referral status, scheduling coordination
- ☐ ALL RECORDS

II: Campbell Psychological Services may receive the following information from the party listed above:

- ☐ Attendance in treatment
- ☐ Intake Summary
- ☐ Treatment Plan & Recommendations
- ☐ Treatment Summary / Progress
- ☐ Progress Notes
- ☐ Assessment / Evaluation Results
- ☐ Discharge Summary
- ☐ Social History
- ☐ Medical Record
- ☐ Medication Management Notes
- ☒ Academic Records including 504 Plan/IEP
- ☒ Teacher Observations / Feedback
- ☐ Completed Rating Scales
- ☐ Court Records
- ☐ Other: ______________________
- ☐ ALL RECORDS

Information is to be used for the purposes of:

☐ Treatment planning   ☑ Coordination of care   ☐ Assessment or Evaluation   ☑ Other: scheduling

This authorization is valid for one year starting from the date of execution unless a different expiration is provided:

☐ Expiration: ______________________   ☑ Expires upon discharge from services at Campbell Psych. Services

I understand that I have the right to cancel this authorization at any time, by providing such request in writing or verbally to a staff member at *Campbell Psychological Services,* 25 East North Street, Carlisle, PA 17013. However, my revocation will not be effective to the extent that information has already been shared based upon this release or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider generally may not require that I sign an authorization in order to receive services, unless the services are being provided to me for the purpose of creating health information for a third party.

I understand I have a right to inspect the materials to be released according to this authorization. I further understand that the potential exists for re-disclosure of my private mental health information by the recipient of that information. Once disclosed, the information may no longer be protected under the HIPAA privacy regulations.

______________________________   __________
Signature of client, if 14 years or older   Date

______________________________   __________   ______________________
Signature of legal guardian, if under 14   Date   Printed Name

______________________________   __________   ______________________
Signature of staff person   Date   Printed Name (and Agency if not Campbell Psychological)

Client has been offered a copy of this release and has ☐accepted ☐declined