Campbell
PSYCHOLOGICAL SERVICES

46 East High 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: South Middleton School District

Address: 4 Academy Street, Suite 100, Boiling Springs, PA 17007

Phone: (717) 258-6484 Fax: (717) 258-4667

**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: status of referral, coordination of appointment times
- ☐ 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: Initiating care, 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,* 46 East High 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