

Chester Springs Counseling

145 Little Conestoga Road
Chester Springs, PA 19425

Authorization for Release/ Exchange of Protected Health Information

Name: _____ Date: _____

SSN: _____ DOB: _____

I hereby authorize **Laura Orsatti Weissflog, MSN, APRN, BC, CRNP** located at: **145 Little Conestoga Road - Chester Springs, PA 19425** to disclose to, or obtain from:

Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

The following specific information:

- Discharge Summary
- Treatment Plans
- Alcohol/ Drug Abuse Diagnosis and/ or information
- HIV/ AIDS Diagnosis Information
- IEP, GIEP
- Other, please specify: _____

The purpose of disclosure: **Collaboration of Care**

Patient Signature: _____ Date: _____

(Patient must sign for him/ herself if 14 years of age or older)

Parent/ Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Duration of release: This completed release/ exchange of information form is good for one year unless length of time is revoked in writing by the patient or appropriate representative.