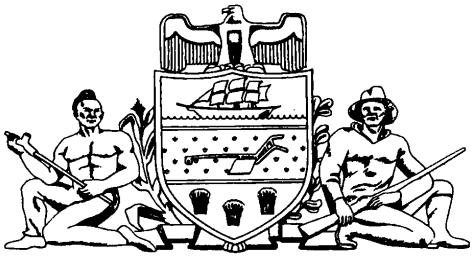
DAUPHIN COUNTY



101 MARKET STREET
HARRISBURG, PENNSYLVANIA 17101
TELEPHONE: (717) 780-6767
FAX: (717) 255-1396

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Facility/Program Name: _Team MISA (Mental Illness Substance Abuse)_____

Address: _____

Phone: _____/Fax: _____

RE: _____

SS #: _____-___-_____

DOB: ____/___/_____

DCP #: _____

I hereby authorize the use/disclosure of health information by _____ to be released/obtained from Team MISA (Mental Illness Substance Abuse)**.** The purpose of this document is to release and/or obtain information at the request of the individual for coordinating ongoing services and planning, and may include:

_____ Medical Treatment/Information

_____ Drug & Alcohol Treatment

_____ Psychiatric Treatment/Information

_____ Court/Criminal Records

_____ Personal Information (Inc. Name, DOB, SSN)

_____ Other: _____

This Authorization will expire one (1) year from the date it is signed. I understand that I may revoke this Authorization, in writing, at any time. I also understand that my revocation of this application will not impact any action taken in reliance on this Authorization prior to the receipt of my written revocation. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the persons listed above and may no longer be protected.

_____	_____	_____
Client's Signature	Client's Name (printed)	Date
_____	_____	_____
Guardian's Signature	Guardian's Name/Relation (printed)	Date
_____	_____	_____
Witness's Signature	Witness's Name (printed)	Date