

**YORK / ADAMS (CASSP)
CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM
INFORMATION RELEASE FORM**

I hereby authorize York/Adams CASSP and the following organizations as marked to release information to and receive information from:

<input type="checkbox"/> Adams County Children & Youth	<input type="checkbox"/> School District
<input type="checkbox"/> Adams County Juvenile Probation	<input type="checkbox"/> Lincoln Intermediate Unit
<input type="checkbox"/> York County Children & Youth	<input type="checkbox"/> Capital Area Intermediate Unit
<input type="checkbox"/> York County Juvenile Probation	<input type="checkbox"/> Community Care Behavioral Health (CCBH)
<input type="checkbox"/> York County Youth Development Center	Please list all others below:
<input type="checkbox"/> York/Adams Early Intervention	<input type="checkbox"/>
<input type="checkbox"/> York/Adams Mental Health-Mental Retardation	<input type="checkbox"/>
<input type="checkbox"/> York/Adams Health Choices Management Unit	<input type="checkbox"/>
<input type="checkbox"/> York/Adams Drug and Alcohol Program	<input type="checkbox"/>
<input type="checkbox"/> Service Access & Management (SAM)	<input type="checkbox"/>

from the record of _____

Name		Birthdate
Address	Zip	School District

The following information will be exchanged for the purpose of referral/case coordination (select all that apply):

<input type="checkbox"/> Psychiatric / Psychological reports	<input type="checkbox"/> Vocational skills assessment
<input type="checkbox"/> Teacher observations / School records	<input type="checkbox"/> Social History / Family Information
<input type="checkbox"/> Progress Reports	<input type="checkbox"/> Attendance Data
<input type="checkbox"/> Medical Reports	<input type="checkbox"/> Report Cards
<input type="checkbox"/> Neurological Reports	<input type="checkbox"/> Admission / Discharge Reports
<input type="checkbox"/> IQ test scores, aptitude and achievement tests	<input type="checkbox"/> Behavior Reports
<input type="checkbox"/>	<input type="checkbox"/>

This release is valid for 12 months from the date of signature and may be revoked by notifying a York/Adams CASSP Coordinator in writing or witnessed verbally. **I understand that treatment, payment, enrollment or eligibility for benefits and services is not subject to signing this release. However, I choose to sign this release voluntarily to receive CASSP coordination services. I have read this form carefully and understand what it means.**

Signature of Minor (age 14 and above) Date

Signature of Parent or Guardian (Relationship) Date

Signature of Witness Date

**** Signature of Witness* *Date*

Verbal release of information (****requires signature from two witnesses*): This section is to be used for consumers who are unable to provide a signature. We have witnessed that the consumer understand the nature of this release and has freely given his/her consent.

In accordance with Pennsylvania Regulations: "This information has been disclosed to you from records whose confidentiality is protected by State Law. State regulations limit your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains."