CAPITAL AREA
Employment 1st Coalition
WORKING TOGETHER FOR A STRONG COMMUNITY

UCP United Cerebral Palsy
of Central Pennsylvania

Authorization to Release Information

Individual's Name: _____ Date of Birth: _____

I do hereby authorize the person and/or agency indicated to exchange such confidential information and records as specified below with UCP Central PA in collaboration with the Capital Area Employment 1st Coalition. You are hereby released from all legal liability that may arise from such release.

External Agency: Name and Position/title: _____

Agency: _____

Address: _____

The following information: (must be specific and in accordance with the" minimum info and need to know" guidelines)

_____

_____

Reason for release: _____

This authorization shall be effective immediately. I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken.

However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. UCP Central PA, its employees, officers, and program staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization form UCP Central PA upon request.

_____ _____

Printed Name and Signature of Individual/Designee Date

_____ _____

Printed Name and Signature of Witness Date