

**DANNY’S HOUSE**

**SOBER LIVING HOUSE FOR WOMEN**

**45 W. Upsal Street**

**Philadelphia, PA 19119**

**Dannys-House.org**

**(267) 277-2609**

[**dannyshouse121@gmail.com**](mailto:dannyshouse121@gmail.com)

## Authorization to Release Information

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Danny’s House to speak to:

Person or Entity authorized to release my information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific information to be released:**

\_\_X\_\_ Participant presence in treatment \_\_X\_\_ Participant prognosis

\_\_X\_\_ Professional Diagnosis \_\_X\_\_ Progress Report(s) and nature of program

\_\_X\_\_ Relapses and frequency of relapses

**This information is released for the following purpose(s):**

\_\_\_\_\_ To confirm presence at Danny’s House sober living program.

\_X\_\_\_ To coordinate treatment efforts

\_\_\_\_\_Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information may be communicated to Interim House in the following manner:**

\_\_\_x\_\_\_ Oral \_\_x\_\_\_\_ Written \_\_x\_ Both

1. This authorization form will expire in one year on \_\_\_\_\_\_\_\_\_\_\_\_\_
2. I understand that I may revoke this authorization by notifying Danny’s House verbally or in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Resident Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Witness Date