JOHN C. HOUTON, PhD LPC CAADC

"Help & Hope for Children and Families"
32 S. 10th Street, Akron, PA. 17501
Phone: 717-341-6004 ● Fax: 717-859-5674

1. Printed name: _____ Date of Birth: _____

2. I authorize John Houton, PhD. to receive and/or disclose the following information:

   - ❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse
   - ❑ Admission and discharge summaries
   - ❑ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents
   - ❑ Treatment, recovery, rehabilitation, aftercare plans and other similar plans
   - ❑ Social, family, educational, and vocational histories
   - ❑ Social work assessments and plans
   - ❑ Progress, nursing, care or similar notes
   - ❑ Evaluations and reports of consultants
   - ❑ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living
   - ❑ Vocational evaluations and reports.
   - ❑ Billing records
   - ❑ Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents
   - ❑ Complete copy of the medical record
   - ❑ Verbal communication
   - ❑ Other: _____

3. To this person or organization _____
   Address: _____ Phone: _____
   Fax: _____

I understand and agree that this Authorization will be valid and in effect until I am no longer a client of John Houton. I also understand that I can revoke or cancel this authorization at any time by notifying the Privacy Officer in writing. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

_____ _____
Signature of client (If age 12 or older) **Date**

_____ _____
Signature of Parent/Guardian/Responsible Party **Date**

_____ _____ _____
Witness **Title** **Date**

This information is disclosed from records whose confidentiality is protected by PA Code Title 55, 5100.4, 5100.33, 5200.41, 5210.26, 5210.56, 5221.52, and Federal Regulations 42 CFR Chapter IV.