AUTHORIZATION AND CONSENT FORM
FOR USES AND DISCLOSURES OF INFORMATION

I, _____, DOB _____, voluntarily authorize that I consent to the release and exchange of information between Erie County Public Defender's Office and the following agency:

Name: _____
Phone: _____
Fax: _____
Address: _____

SUCH INFORMATION THAT IS SUBJECT OF THIS AUTHORIZATION AND WHICH WILL BE USED OR DISCLOSED AS SET FORTH BELOW:

Information disclosed will be used to facilitate referral process to Erie County Public Defender's office for engagement in the Project Strength and for ongoing involvement in the program. Information will be used with application to determine if eligibility requirements are met for participation in project and for purpose of coordination of care while engaged in services with Erie County Public Defender's office. I understand I may revoke this authorization in writing at any time, except to the extent that action has been taken.

Purpose or need for information disclosure (check all that apply): Project Strength

I understand that information will be disclosed only for the purpose(s) noted above and that the amount of information to be disclosed will be limited to the following:

_____ Summary of need for services

_____ Demographic Information

_____ School Records

_____ Treatment Summary

_____ Diagnosis

_____ UDS Results

_____ Attendance

_____ Progress

_____ Other: _____

Start Date: _____

This authorization will expire on: 30 days after closure of participation.

I understand that the information in my record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

_____

Signature Date

_____

Witness Date