Forgiven Ministries, Inc.
To Love and Encourage, the hurting, the broken, the forgotten, the lost, and the lonely.
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forgiven-ministries.org | info@forgiven-ministries.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL & PROTECTED HEALTH INFORMATION:

Forgiven Ministries, Inc. believes that it is important that we communicate openly with your supervision / treatment provider staff. As such, Forgiven Ministries, Inc., would like your permission to communicate, when necessary, with your supervision staff and /or treatment provider(s). The groups or individuals that may be asked to release information include but are not limited to:

Pennsylvania Department of Corrections
Pennsylvania Board of Probation & Parole (Includes: Sexual Offender Assessment Board)
Community Corrections Center
Mental Health Treatment Providers
Drug & Alcohol Treatment Providers
Veterans Administration
Medical Treatment Providers

I agree that a photographic or facsimile copy of this authorization may be deemed to be the equivalent of the original and may be used as a duplicate original. The original of this authorization is on file with Forgiven Ministries, Inc. and will stay in effect 15 months from the date signed.

SECTION A: Client Information

Name of Client / Tenant:	**Date of Birth:**
Parole Number: (if known) or DOC #:	**Telephone Number:**
Address:	**Primary Supervision Staff:** _____ **Erie Community Corrections Center** _____ **Pennsylvania Department of Probation & Parole** _____ **Erie County Adult Probation & Parole** _____ **Other (Specify: _________________________________)**

I, ____hereby, authorize and direct any Federal, State or local agency, organization, mental health or drug & alcohol treatment provider, business or individual to furnish information concerning myself to Forgiven Ministries, Inc., and/or any duly authorized representatives of Forgiven Ministries, Inc. I am aware that this form may be used to collect sensitive information, which is protected by the Privacy Act. This information will not be disclosed or released outside of Forgiven Ministries, Inc. except to appropriate Federal, State and local agencies, when relevant, and to civil, criminal or regulatory investigators and prosecutors.

This release of information shall be limited to the following specific types of information: (Please Initial)

____ Assessment / Treatment ____ Educational / Parole Information ____ Parole Plan / SOAB Assessment
____ Continuing Care Plan ____ Employment Status ____ Presence / Participation in treatment
____ Medical & Mental Health Treatment / Aftercare Planning

The purpose if this disclosure of information is to:

1. ***To evaluate my readiness / ability to participate in Forgiven Ministries, Inc. programs.***
2. ***Used to determine program and transitional housing rental eligibility***
3. ***Assist in Improving my reintegration into society and assisting Forgiven Ministries, Inc., to better serve you.***
4. ***For the ongoing exchange of information between Forgiven Ministries, Inc. and Parole Supervision Staff / Treatment Provider(s)***
5. ***If other purpose, please specify: ____***

I understand that I may refuse to sign this authorization. However, If I or my duly authorized representative fail to sign this authorization, I understand that this action may constitute grounds for denial of eligibility or termination of assistance or tenancy, or both. I understand that I have a right to review my file and provide updated information that substantiates any errors.

SECTION B-Special Categories of Medical Information

B-1 Drug and Alcohol Information

If my medical record includes drug and alcohol information, I want to send that information to the individual/organization identified in Section A of this form. _____ Yes _____ No

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B-2 Mental Health Information

If my medical record includes mental health information, I want to send that information to the individual/organization identified in Part A of this form. _____ Yes _____ No

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Forgiven Ministries, Inc. in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. Forgiven Ministries, Inc., agrees to treat all information received from the above entities as confidential and disclosure by the recipient is prohibited, unless expressly permitted by the undersigned or someone authorized to act on their behalf.

Client / Tenant Signature: ____ Date: ____________________________

For Office Use Only