## COMPEER PROGRAM REFERRAL RELEASE

## AUTHORIZATION TO EXCHANGE CLINICAL INFORMATION

I, ________________________________________, hereby authorize the staff of
**(CLIENT'S NAME)**
The Compeer Program and ____________________________________ to exchange
**(PROVIDER/PROVIDING AGENCY)**
information or records, verbally or in writing, pertaining to services or treatment received by me. This information can also be shared with ________________________________,
**(COMPEER VOLUNTEER)**
my Compeer Volunteer to be named at a later date.

Information and records covered by this authorization include details of my admission, discharge, course of medical & psychiatric treatment, and all other services with which I have been involved.

The purpose of this authorization is to assure continuity of my care and the timely communication between these agencies of information & events, including my hospitalizations that may be pertinent to each in offering services to me.

I certify that I am at least 18 years old and have given this authorization voluntarily. I understand that this authorization and my Compeer Referral will expire in twelve (12) months from the date of my signature below, at which time I will need to have a new referral submitted to renew my interest in Compeer. I further understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance there of) by written notice to the Program Director of Compeer, 411 Dartmouth Ave., Swarthmore, PA 19081.

**X____________ Provider/Providing Agency please initial for AXIS I MH Diagnosis**

______________________________ ______________________________
Witness My Signature*

______________________________ ______________________________
Witness Date of Authorization

* In the event that a person is physically unable to sign, but gives verbal or behavioral consent, the signature of two witnesses to the person's understanding and consent will suffice.