COMPEER PROGRAM REFERRAL RELEASE

AUTHORIZATION TO EXCHANGE CLINICAL INFORMATION

I, _____, hereby authorize the staff of the Compeer
(CLIENT'S NAME)
Program and _____ to exchange information or records,
(PROVIDER/PROVIDING AGENCY)
verbally or in writing, pertaining to services or treatment received by me. This information can also be shared

with _____, my Compeer Volunteer to be named at
(COMPEER VOLUNTEER)
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 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.