CompeerCORPS
Friendship. Support. Camaraderie.

Date of Referral: _____/_____/____

RELEASE OF INFORMATION: CompeerCORPS Program

Mental Health Association in Butler County
140 North Elm Street, Suite A
Butler, Pennsylvania 16001

Phone: (724) 287 - 4083
Fax: (724) 287 - 7090

I, _____, do hereby consent to and Authorize _____ to disclose to the

_____ Mental Health Association
_____ CompeerCORPS Program Coordinator / Volunteer
_____ Mental Health Advocate
_____ Other: _____

Information from my case records. I understand the reason for this ***Release of Information*** is to facilitate program guidelines, and to allow program coordinators and advocates to discuss information with collaborative agencies, providers, or others for the purpose of helping with a specific problem or complex situation.

I understand that information discussed in consultation and networking with services could include:

Social Services _____ Therapy Notes _____ Medication Maintenance _____
CompeerCORPS _____ Substance Abuse (Drug/Alcohol) _____ Housing _____
VA Recovery _____ other (please explain): _____

This statement must be signed upon entering the CompeerCORPS Program or programs at the Mental Health Association and may be revoked at any time. This Release of Information will remain confidential and in compliance with the Mental Health Association's HIPAA policy guidelines. This Release of Information will remain in force for a reasonable period of time and may be updated periodically.

Signed: _____

Witness: _____

Date: _____