Forgiven Ministries, Inc.
To love and encourage, the hurting, the broken, the forgotten, the lost, and the lonely

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Authorization for Use or Disclosure of Personal & Protected Health Information

(A photographic or facsimile copy of this authorization is deemed to be equivalent of the original.)

Forgiven Ministries, Inc., believes that it is important to openly communicate 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). This form is to be used by Forgiven Ministries, Inc. in pursuit of the above. Please print clearly; each section needs to be completed to be valid.

I understand that Forgiven Ministries, Inc., is not a health care provider covered by federal privacy regulations. The information described below may be redisclosed and no longer protected by these regulations. Forgiven Ministries, Inc., may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality requirements.

The groups or individuals that may be asked to release information include but are not limited to:

Federal, State & County Department of Corrections (Includes Corrections Counselors & Unit Management)
Pennsylvania Board of Probation & Parole (Includes Sexual Offender Assessment Board)
Community Corrections Center(s)
Mental & Behavior Health / Drug & Alcohol Treatment Providers
Medical Treatment Providers / Veterans Administration
Applicant's / Participant's Ongoing Employment Provider(s)

APPLICANT INFORMATION:

Applicant's Name (Printed)	**Dare of Birth**
Parole / DOC#:	**Institution:**
Anticipated Release Date:	**Parole Officer / Unit Manager / Counselor**
Length of Incarceration:	**Committing County / Jurisdiction**

Section A: **(Applicant's Signature Required)**

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 the address listed above 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:

- **Federal, State, County Parole & Department of Corrections** (includes: Assessments (Risk, treatment & SOAB), Presence & Participation in treatment / aftercare planning, employment status, Personal Information, Overall characterization of supervision adjustment & violation status and Continuing care plan etc.)
- **Behavioral & Mental Health Treatment** (includes: Assessments (Risk, treatment & SOAB), Presence & Participation in treatment / aftercare planning, Medication & Personal Information, Continuing care plan etc.)
- **Ongoing Employment Providers (**disciplinary, termination, attendance information**)**

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 & communication between Forgiven Ministries, Inc., the Department of Corrections, Parole Supervision Staff and Treatment Provider(s) including disciplinary notes, behavioral history or issues.***
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 / inspect my file and receive a copy of the material disclosed and provide updated information that substantiates any errors.

SECTION B-Special Categories of Medical Information

B-1 Drug and Alcohol Information

If my medical or treatment record includes drug and alcohol information, I want to send that information to the individual/organization identified in Section A of this form. __x__ 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 or treatment record includes mental health information, I want to send that information to the individual/organization identified in Part A of this form. __x__ 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.

Applicant / Participant Signature: _____Date: _____

This authorization will expire in 1 year from the date of signature unless another date is specified: _____

_____ By checking this line, I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

_____ By checking this line, I authorize the release of records for future visits after the date of my signature until this authorization expires or is revoked.

Office Use Only:

Applicant's Date of Initial Contact:	**Institutional Contact (Person / Date / Time**
Form(s) Sent	**Form(s) Returned**
Applicant's Release Date:	**Primary Supervision Upon Release:**

Additional Note(s) / Comment(s)