Authorization to use or Disclose Client Information

This form MUST accompany a completed HOPE Fund Application.

I authorize the use and/or disclosure of my confidential information as described below:

Person and/or organization initiating this written authorization:

Name _____Organization _____

Persons and/or organizations authorized to receive/use/disclose the information:

__X__ The HOPE Fund of Penns Valley
__X__ All Community Safety Net agencies.

American Red Cross	Catholic Social Services	C.C. Office of Adult Services
Centre Volunteers in Medicine	Community Action	Community Help Centre
Food Bank of State College	Housing Transitions	Interfaith Mission
MidPenn Legal Services	Salvation Army	St. Vincent de Paul Society
C.C. Youth Service Borough	Women's Resource Center	Bellefonte Faith Centre

_____ C.C. Adult Services CM	_____ C.C. Assistance Office	_____ C.C. Base Service Unit
_____ C.C. Basic Needs CM	_____ C.C. Children and Youth Services	_____ C.C. Domestic Relations
_____ C.C. Housing Authority	_____ C.C. Housing CM	_____ C.C. Probation and Parole
_____ Comm. Residential Rehabilitation	_____ Good Shepherd Catholic Church	_____ HelpMates
_____ Home Instead	_____ Mt. Nittany Medical Center	_____ Office of Vocational Rehabilitation
_____ Police	_____ Private Industry Council of C.C.	_____ Social Security Administration
_____ St. Andrew's Episcopal Church	_____ Veteran's Administration	_____ Women, Infants, and Children

_____ Other: _____

Description of information that may be shared: __X__ All Information

_____

_____

Purpose of disclosing information:

_____

This authorization expires in one year or on _____. (Specify date if less than 1 year)

- I understand that the persons or organizations that receive this information may not be bound by The HOPE Fund of Penns Valley or any of the companies named herein rules of confidentiality.
- I understand that refusal to sign this authorization will not terminate services provided by the initiating HOPE Fund of Penns Valley or of the entities named herein, but that it may hinder provision of services that might be provided by other organizations.
- I understand that I may revoke this authorization by making a request in writing to The HOPE Fund of Penns Valley or any of the entities named herein that initiated this authorization. I also understand that any information released prior to my written request to revoke this authorization cannot be retracted.
- I understand that I have the right to review a summary of any records pertinent to my use of services provided by The Hope Fund of Penns Valley or any of the entities named herein that initiated this authorization.

_____ _____ _____
Signature of client, legal guardian, or representative Date Printed name

_____
Relationship of signer to client

_____ _____
Signature of witness Date