



# GREEK ORTHODOX ARCHDIOCESE OF AMERICA

## GREEK ORTHODOX LADIES PHILOPTOCHOS SOCIETY, Inc.

### CONSENT FOR RELEASE OF INFORMATION

DATE: \_\_\_\_\_

To be completed by Philoptochos Social Work Department:

TO: \_\_\_\_\_  
\_\_\_\_\_

FROM: Paulette Geanacopoulos, LMSW  
Director, National Philoptochos Department of Social Work Services  
126 East 37<sup>th</sup> Street, New York, NY 10016  
Confidential Social Work Telephone: 212.977.7782 • Email: PauletteG@philoptochos.org

Signature of person requesting information \_\_\_\_\_

### TO BE COMPLETED BY CLIENT:

RE: Name of Client: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: XXX – XX - \_\_\_\_\_

I, \_\_\_\_\_ am a client of the Social Work Department of National Philoptochos, the philanthropic arm of the Greek Orthodox Archdiocese of America. I hereby authorize your release to National Philoptochos of all assistance and services provided to me by you/your organization, and/or other information as described below that is in my case record. I understand that the information to be released is confidential and protected from disclosure. I understand that I have the right to cancel my permission to release information either orally or in writing at any time before it is released. I understand that the information provided may not be re-disclosed without my consent or under other authorization. I further understand that my consent to release information will expire when acted upon, or 180 days from the date signed, whichever occurs first. (A photostatic, scanned or facsimile of this authorization shall be considered as valid as the original).

DATE SIGNED: \_\_\_\_\_

Signature of Client: \_\_\_\_\_

Printed Name of Client: \_\_\_\_\_

### **WITNESSED BY:**

Signature of Witness: \_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_

### **If client is a minor or incapacitated:**

Signature of Guardian or Legal Representative: \_\_\_\_\_ Relationship \_\_\_\_\_

### **EXTENT OR NATURE OF INFORMATION BEING REQUESTED:**

Medical, mental health information, history of substance use disorder or addiction, history of violence, including evaluation, diagnosis, treatment and dates of treatment, admission and discharge; outpatient services; medication(s) prescribed and length of time on such drugs; psychosocial history; psychological testing and course of treatment; legal history; family and social service information and history; entitlement/benefit information and history from government and/or other resources; financial assistance requested/provided.

**PURPOSE OF REQUEST:** To assist in the assessment of the client; to verify information provided by client; to assist in developing an effective and appropriate service plan that may assist the client to manage in the future.