Date _____/_____/_____ Client Number: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, whose Date of Birth is _____, authorize
Patient/Client

Revive, Center for Wellness to disclose to and/or obtain from:

_____ the following information
Name of Person/Title of Person/Organization

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

___ Assessment
___ Diagnosis
___ Psychological Evaluation
___ Psychosocial Evaluation
___ Psychiatric Evaluation
___ Treatment Plan or Summary
___ Current Treatment Update
___ Medication Management Information
___ Presence/Participation in Treatment
___ Nursing/Medical Information
___ Toxicological Reports/Drug Screens
___ Educational Information
___ Discharge/Transfer Summary
___ Continuing Care Plan
___ Progress in Treatment
___ Demographic Information
___ Other _____
___ Other _____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and coordinate treatment services when appropriate.

If other purpose, please specify: _____
_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Revive, Center for Wellness, in person or mailed to 37 Glenbrook Road, Stamford, CT 06902. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated:

_____

Conditions

I further understand that Revive, Center for Wellness will not condition my treatment on whether I give authorization for the required disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by the authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc).

___ Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness

_____ Medications: _____