RELEASE OF INFORMATION

PARTICIPANT'S NAME (Print): ____ **DOB:** ___________

I AUTHORIZE ________________________________ **TO RELEASE INFORMATION TO:**

Primary Service Provider: ____

Specific Organization/Person **Address**

INFORMATION THAT MAY BE RELEASED:

( )Mental Health/Physical Information:)( ) Presence and Progress in Treatment ( )Assessments ( ) Diagnoses
( ) Tx/Recovery Plans ( ) Psychiatric Summary ( )Medication Records
( ) Demographic Information

☐ Other: ____

REASON: ( ) Provide continuity of care ( ) Compliance with program ( ) Specify ______________________
( ) Personal Use ( ) Legal Purposes ( ) Social Security/disability ( ) Insurance/Managed Care

DATES OF SERVICE: FROM ____________**TO** ________________________

The information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making disclosure of it without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Note: Person's authorized by the patient means the parent, guardian or legal guardian or legal custodian of a minor client, the guardian of a client adjudged to be incompetent, the person representative of spouse of a deceased client or any person authorized in writing by the client. If no spouse survives a deceased client, an adult member of the deceased client's family may qualify. A court appointed temporary guardian may also qualify to consent to the release of information.

This authorization shall expire one hundred eighty days (180) from the date of the signing or termination of treatment, whichever is sooner. I understand that this consent may be revoked by me, my parents, or legal guardian in writing at any time, but it is not retroactive to any information already released.

This form has been fully explained and I certify that I understand its contents. I understand that a Renew Wellness Practitioner may not condition treatment on obtaining this consent/authorization from me.

____ ________________

Participant's Signature or Oral Consent when physically unable to sign Date
"I understand the nature of the release and freely give oral consent"

____ ________________

Signature of Authorized Person in lieu of Participant Date
( ) Power of Attorney; ( ) Guardianship Order

______________________________ ______________________________

Witness Signature Date Oral Consent/Witness Signature Date

( ) Copy Accepted ( ) Copy Refused