AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, _____, _____, authorize
(Name of Client) (Birth Date) (SS Number)

Peak Wellness Center, Inc. to **release to / receive from (circle one or both):**

Name: _____

Address: _____

Telephone Number: (_____)_____ Attention: _____

Peak Wellness Center, Inc. staff will only release documents originated by Peak Wellness Center, Inc.

Client Initial for verbal and/or written information to be **released** and/or **received** (circle one or both):

_____Clinical Assessment	_____Diagnostic Impressions	**Requests from others only**
_____Psychiatric Evaluation	_____Progress Notes	_____Court Documents
_____Psychological Evaluation	_____Discharge summary	_____Probation/Parole Documents
_____Psychological Test Results	_____ASI	_____Other (specify):
_____Treatment Plan	_____ASAM	
_____Medication Records	_____Other (specify):	

Purpose or need for disclosure: _____

_____

I understand that my records are protected under the Federal and Specific State confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may, in writing, revoke this consent at any time, except to the extent that action has been taken in reliance on it (such as the provision of treatment upon consent to disclose to third-party payers) or after the occurrence of a specified ascertainable event (e.g. completion of legal requirements). In any event, this consent expires automatically as described below. I acknowledge that the information released was fully explained to me and this consent is given of my own free will.
The information I authorize for release may include records which may indicate the presence of substance abuse or communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome.

This consent expires ___/___/___ or no later than termination of treatment. Executed this _____ day of _____.

_____
Client

_____ _____
Parent, guardian or person authorized to sign for client Witness

_____

TO RECIPIENT:
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal and State regulations prohibit you from making any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical 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. (Release: 10/96, 2/00, 5/01, 3/03, 9/04, 7/10, 3/11, 8/12 DQM)