Logo

Consent to Release Confidential Information

1. I, _____ (dob: _____),
   (Person's Name)
   do hereby authorize Divine care health and wellness LLC to:

   □Disclose to, and/or □ Re-disclose to, and/or □ Request from

2. Name: _____ of (Agency Name) _____

   Address: _____

   Phone: _____ Fax: _____ Email: _____

   Relationship to person: _____

3. Information to be disclosed/requested: (ALL ITEMS NEED TO BE CHECKED 'Y' OR 'N')

Y	N	
□	□	Presence in treatment, prognosis, description of progress, potential for relapse
□	□	Medical History
□	□	Most recent physical exam, including most recent blood work, toxicological screen and TB results
□	□	Results of Toxicological screens
□	□	Discharge/Transfer Summary
□	□	Aftercare Plan
□	□	Individual Action Plan (most recent)
□	□	Third Party Payer and Funding Source information
□	□	Psychological/Psychiatric evaluation
□	□	Other: _____

4. Purpose of the disclosure: (ALL ITEMS NEED TO BE CHECKED 'Y' OR 'N')

Y	N	
□	□	To provide ongoing treatment and/or aftercare
□	□	To coordinate treatment with family member/concerned other
□	□	To coordinate treatment with medical personnel
□	□	To provide treatment update to Third Party Payers and/or funding sources
□	□	Other: _____

5. I understand that my records are protected under Federal Regulations 42 CFR Part II, Confidentiality of Alcohol and Drug Abuse Records and HIPAA regulations. Information cannot be disclosed without consent except otherwise stated by law. I willingly and voluntarily choose to sign this release for the purpose(s) specified above. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I understand that you may be transmitting information electronically and authorize you to do so. If another party receives the information in error, I absolve Divine care health and wellness, LLC of any liability relating to such error. I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment or healthcare operations if permitted by State law.

   If not previously revoked, this consent will terminate upon completion of care or on the following date, event or condition: _____

6. Signature of Person: _____ Date: _____

7. Signature of Parent/Legal Guardian (if needed): _____ Date: _____

8. Signature of Witness: _____ Date: _____

The above information and its purposes have been explained to me, and I have been given the opportunity to ask questions regarding any and all above.

Signature of Person/Parent/Guardian: _____ Date: _____