Perspectives Treatment Center, Inc.

Consent for Release of Information

Client's Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **DOB:** _____

I, _____, (<<< print client name),
authorize Perspectives Treatment Center (PTC) to both Release & Receive information
To & From the following person/organization:

Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

This release includes information from the client's Medical Record, but not the original or copy of the actual Medical Record. A separate authorization, as defined by HIPAA, is required for actual psychotherapy notes.

_____ **Progress In Treatment Report(s)**
_____ **Diagnostic Summary**
_____ **Urine Drug Screen results**
_____ **Treatment Plan & Interventions**
_____ **Treatment Summary**
_____ **Post Treatment Recommendations**
_____ **Other, (must specify)specify:** _____

The above information will be used for the following purposes:

_____ **Obtaining/Releasing Information to/from Collateral Participants in Patient's Care; including, but not limited to, Prior Treatment Providers, Current Treatment Providers, Family, Spouse, Providers of Continuing Care.**

_____ **Reporting to EAP's, Court, Attorney, Identified Court Representative, Judge, Probation/Parole Officer.**

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states very, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.
Your relationship to client:
___Self___Parent/legal guardian ___Legal representative ___Other (describe) _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

CLIENT'S SIGNATURE: _____ **Date** ___/ ____/ ___

Parent/guardians/personal representative (if applicable)

Signature: _____ **Date** ___/ ____/ ___

Witness (if client is unable to sign)

Signature: _____ **Date** ___/ ____/ ___