

RECOVERY CARE

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____

Date of Birth _____

I authorize the following person or organization to disclose information:

Clinic / Physician / Organization _____

Street Address _____

City _____

State _____

ZIP Code _____

To: Recovery Care

37 Carroll Avenue, Keyser, WV 26726

Information Authorized for Disclosure

I authorize disclosure of the records or information indicated below, which may include medical, psychiatric, substance-use-disorder, sexual health, and sexually transmitted infection information to the extent specifically authorized and permitted by law.

- ☐ Whether I am currently participating in treatment
- ☐ Diagnosis and/or prognosis
- ☐ Brief description of treatment progress
- ☐ Information regarding relapse or recurrence, when applicable
- ☐ Evaluation date and recommendations
- ☐ Progress letter
- ☐ Treatment dates
- ☐ Reports describing compliance with treatment recommendations
- ☐ Discharge status
- ☐ Other: _____

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Terms, Expiration and Revocation

Purpose of disclosure: treatment, care coordination, payment, legal/administrative purpose, or other purpose specified here: _____.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. Unless I specify an earlier date or event, this authorization will expire one year from the date I sign it, or as otherwise required by applicable law.

I understand that information disclosed under this authorization may be subject to federal and state confidentiality protections. Certain substance-use-disorder records are protected by federal law, including 42 CFR Part 2, and redisclosure may be restricted except as permitted by law or with appropriate authorization.

I understand that signing this authorization is voluntary unless disclosure is necessary for a purpose permitted by law. I may request a copy of this signed authorization.

Patient Printed Name _____

Patient Signature _____

Date _____

Witness Printed Name _____

Witness Signature _____

Date _____