Pavillon
A Center for the Treatment of Alcoholism and other Drug Addictions

Medical Records Authorization to Release Information (*ONE PERSON/ORG Per RELEASE*)

I, (Patient Name)_____(DOB:_____) hereby authorize Pavillon to release information to and/or obtain information from the following individual(s) and/or organizations:

Send records to:

Organization Name (if applicable) Dates of Service:

Name: Title/Relationship:

Address:

City/State/Zip:

Phone: Fax:

Email:

INFORMATION TO BE RELEASED:

- ☐ Letter (Attendance, Completion, etc.)
- ☐ History & Physical
- ☐ Labs (Bloodwork, genetic and drug tests)
- ☐ Medication Info/MAR
- ☐ Medical & Nursing Notes
- ☐ Integrated Clinical Summary
- ☐ Psychological Evaluations and Psychological Notes
- ☐ Psychiatric Evaluations and Psychiatric Notes
- ☐ Treatment Plan
- ☐ Clinical Progress Notes (TPR, Individual, Family, General, DAP, Intake, Group, IOP Session, etc.)
- ☐ Early Intervention Plan
- ☐ Continuing Care Plan & CCP Notes
- ☐ Discharge Summary
- ☐ Four Day Professional Assessment Summary
- ☐ Four Day Professional Assessment Evaluation
- ☐ Outpatient Assessment/Evaluation (GOS)
- ☐ GOS Professional Assessment Evaluation

☐ Other: _____

☐ Any and all records and other information, whether recorded or not, created by, received or acquired by Pavillon, including, but not limited to, all the specific information listed in this release

INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE:

☐ Continuation of Care ☐ Legal Reasons ☐ Other_____

I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form. This consent shall expire in eighteen (18) months after the date of my signature unless this earlier date/event/condition_____. I agree that this length of time is no longer than reasonably necessary to serve the purpose for which the release is given. I understand that I may revoke this consent (in writing) at any time. If I choose to revoke this consent in the future, I understand that such future revocation cannot apply to information already released and/or obtained under authority of this release prior to the date of such revocation. This consent is subject to revocation at any time except to the extent that Pavillon has already acted in reliance on it. I understand that receiving services will not be made contingent on signing this or any other authorization to release information.

I understand that my drug and alcohol treatment records are protected under the Federal regulations governing confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. parts 160 & 164 and state laws regarding privilege and cannot be disclosed without my written consent unless otherwise provided for by the regulations or state law. By signing, I am voluntarily providing written consent to release the above described records and waive any state privilege relating to the records.

Patient Signature: Date:

Witness Signature: Date: