Written Consent to Disclose Medical Records and Information

Client Information

Client Name (First, Middle, Last)	Other Names Used in Treatment	Date of Birth
Client Address		Daytime Phone

Release Purpose

Check the appropriate boxes or write in other purpose

☐ Personal ☐ Treatment/Continuing Care ☐ Insurance ☐ FMLA/Disability ☐ Verify Attendance ☐ Employment
☐ Legal ☐ Health Emergency Contact ☐ Family Education/Wellness ☐ Other (specify): _____

Release Information TO

I authorize Aware Recovery Care, Inc., its subsidiaries, and affiliated entities (collectively, "ARC") to communicate with and release information to the following (an individual name must be included unless recipient is a healthcare provider):

Name	Attention To	Relationship to Client (e.g. spouse, child)
Address (street)		Phone
Address (City, State, Zip)		Fax
Email (Print clearly)		

Preferred Delivery Method

☐ Mail ☐ Fax ☐ Email ☐ Verbal Only ☐ Other (specify) _____

Records and Information to be Disclosed or Released

Timeframe to Be Released □ All Dates of Service **OR** □ Specific Dates: From _____ to _____

☐ Complete Medical Record ☐ Face Sheet/Insurance Info ☐ Medications ☐ Labs/Test Results/X-Rays
☐ Assessments/Evaluations ☐ Progress/Continued Care ☐ Treatment Plan ☐ Discharge Summary/Notes
☐ Records for Insurance Appeals ☐ Records for Disability/FMLA ☐ Financial/Billing ☐ Emergency Contact/Notification
☐ Dates of Treatment Letter (***also include if marked***): ☐ Discharge Status ☐ Recommendations/Plan
☐ Other (specify): _____

Information and records may include reference to my HIV/AIDs status: ☐ Include **OR** ☐ Do **NOT** Include

Signature and Date

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR part 2, 45 CFR part 164/HIPAA), and/or state privacy laws. Disclosure is allowed only with my authorization except in limited circumstances described in the Aware Privacy Notice.
- Information used or disclosed pursuant to this consent may be subject to redisclosure by the recipient and may no longer be protected by HIPAA. Various state and federal laws and regulations, including 42 CFR part 2, may prohibit the redisclosure of certain records and information, such as those related to substance use disorder, HIV/AIDs, and psychotherapy.
- Communications resulting from this authorization will reveal that I received services from Aware Recovery Care.
- I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal law, and I may request a copy of this signed consent.
- I can revoke this consent at any time except to the extent that action has been taken in reliance on it by sending written notice to Aware Recovery Care, Inc., Attention: Medical Records Department, 35 Thorpe Avenue, Suite 104, Wallingford, Connecticut 06492. This authorization will expire in one year from the date I sign it unless I request an earlier expiration.
- Treatment may not be conditioned upon my agreement to sign this consent, unless I am receiving care solely to create protected health information for disclosure to another party (*see* 42 CFR § 164.508(b)(4)(iii)), or if disclosure is for the purpose of treatment, payment, or healthcare operations
- This authorization may be used by Aware Recovery Care owned or managed programs upon transfer of my care to them.

Client Signature	Date (mm/dd/yyyy)
Parent/Guardian Signature (when required)	Date (mm/dd/yyyy)
Parent/Guardian Printed Name	