AWARE
RECOVERY CARE

Written Consent to Disclose Medical Records and Information

Client Information

Client Name (First, Middle, Last)	Date of Birth
Client Address	Daytime Phone

Release Purpose

Check the appropriate box or write in other purpose.

□ Personal □ Continuing Care □ Insurance □ Legal □ Disability □ Employment □ Workers' Compensation
□ Health Emergency Contact □ 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 and Relationship to Client (e.g. spouse, child, attorney)	Attention to
Address (street)	Phone
Address (City, State, Zip)	Fax
Email (print clearly)	

Delivery Method

□ Mail □ Fax □ Email □ Verbal □ 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	□ Labs/X-Rays	□ Medications	□ Mental Health
□ Chemical Dependency	□ Discharge Summaries/Notes	□ Treatment Plan	□ Progress Notes
□ Face Sheet/Insurance Info	□ Records for Insurance Appeal	□ Records for Disability/FMLA	□ Financial Records

□ Letter with Dates of Treatment (*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 ARC 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. However, 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 ARC.
- 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, 386 Main Street, Suite 422, Middletown, CT 06457. 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 ARC 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	