FILL IN ALL BLANKS
OTHERWISE AUTHORIZATION
IS INVALID

MIRMONT TREATMENT CENTER
100 YEARSLEY MILL ROAD
LIMA, PA 19063-5593
PHONE: (484) 227-1400 FAX: (484) 227-1513

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Date of Birth: _____

I, _____, do hereby consent and authorize Mirmont Treatment Center as noted below to release to:

Name/Organization _____ Relationship to Patient: _____

Address: _____

_____

Phone _____ Fax: _____

The following information pertaining to MYSELF.

THE INFORMATION THAT MAY BE RELEASED IS LIMITED STRICTLY TO THE FOLLOWING:

( ) Presence in treatment (admission/discharged dates)
( ) Diagnosis
( ) Brief description of progress and prognosis
( ) Nature of the program
( ) A short statement as to whether the client relapsed into drug or alcohol abuse while in treatment and the frequency of such relapse
( ) Other (specific)_____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE(S):

(Be specific): _____

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purposes specified above. I understand that I may revoke this consent at any time by notifying my counselor verbally or in writing, except to the extent that action has already been taken in reliance on my written consent.

42 CFR-2.32

This information has been disclosed to you from records protected by the federal confidentiality rules (42-CFR, part 2). The federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally prosecute any alcohol or drug patient. This fax and files transmitted with it are confidential and are intended solely for the use of the individual or entity to which they are addressed. This communication may contain material protected by HIPAA legislation (45CFR, Parts 160&164). If you are not the intended recipient or the person responsible for delivering this fax to the intended recipient, be advised that you have received this fax in error and that any use, dissemination, forwarding, printing or copying of this fax is strictly prohibited. If you have received this fax in error, please notify the sender by replying to this fax and then shred the faxed information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

_____
Expiration Date

Patient was offered a copy of this consent and it was:
_____Received _____Rejected

Patient Initials _____