



(The Center for Life Enrichment)

Authorization to Release Information

- _____ I authorize Ardent to request records from the following office:
- _____ I authorize Ardent to release records to the following office:
- _____ I give Ardent permission to speak verbally with the following individual/office:

(Name of Facility or Clinician)/Nature or Relationship to Patient

(Address)

(City, State, Zip)

(Phone Number)

(Fax Number)

The following information on _____
(Patient's Name) **(Date of Birth)**

Please release the following information (or specify):

- | | |
|---|---|
| <input type="checkbox"/> Verbal Information | <input type="checkbox"/> ALL INFORMATION |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Medical History/Physical | <input type="checkbox"/> Treatment Plan/Patient Progress |
| <input type="checkbox"/> Psychologist Evaluation | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Results of Drug and Alcohol Treatment or Testing |
| | <input type="checkbox"/> Other (specify) _____ |

For the Purpose of: _____

Approximate Dates of Service: _____

Release Expiration Date: _____ **Not to exceed 90 days** (Consent subject to revocation at any time.)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed authorization form showing when my records have been sent.

Signature of Patient / Responsible Party if Minor _____
Date

Signature of Witness _____
Date

Signature of Clinician #1 _____
Date

Signature of Clinician #2 _____
Date

Signature of Clinician #3 _____
Date

Date Records Sent: _____
Initials of Records Keeper

*** There is a standard processing fee of \$30.00 for any medical records that are released outside of physician offices. Also, all patient responsibility balances must be paid in full before any medical records are released. ***