

PROFESSIONAL RENEWAL CENTER®
Authorization to Release/Disclose Information

Patient Name (please print) _____
Other Names used in treatment, if Any _____
Birth Date _____ Last 4 digits of Social Security Number _____
Address _____ Phone Number _____

I hereby authorize the staff of the Professional Renewal Center® and its employees, agents, or consultants to:

Disclose information to

Name: _____ Relationship: _____

Company: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone Number: _____ Fax: _____

the following information (place an X by the items allowed in the communication):

- | | |
|---|---|
| 1. ___ History & Physical Exam with corresponding Lab Work | 13. ___ Treatment Plan |
| 2. ___ Drug Testing | 14. ___ Treatment Status Updates- Verbal and/or Written |
| 3. ___ Diagnosis | 15. ___ Treatment Discharge Summary |
| 4. ___ Evaluation Recommendations | 16. ___ Fitness for Duty Letter |
| 5. ___ Evaluation Summary for Facility | 17. ___ Aftercare Agreement |
| 6. ___ Assessment Discharge Summary | 18. ___ Prognosis |
| 7. ___ Personal Life Data | |
| 8. ___ Reason(s)/Concern(s) Leading to Referral | |
| 9. ___ Data on my functioning in the ABMS/ACGME 6 core competency areas | |
| 10. ___ Financial Information | |
| 11. ___ Raw Test Data (will be released only to a licensed psychologist trained to interpret the data {KAR 102-1-10a (j)(6)}) | |
| 12. ___ Other (please specify): _____ | |

The purpose of the disclosure is for: ___ Further Assessment and/or Treatment ___ Other: _____

I understand that it is the policy of the Professional Renewal Center®, and its employees, agents or consultants to release only that information about a client or a former client which, in the judgment of the staff, is considered essential for the above purpose.

I understand that the records released may contain alcohol and drug treatment or psychiatric/psychological/psychosexual information. I understand this communication will reveal my presence as a patient in an assessment/treatment facility. Where alcohol/drug abuse information has been disclosed through records that are protected by federal law, or mental health information has been disclosed through records that are protected by state law, further disclosure is prohibited without my specific written consent, or as otherwise permitted by such laws and/or regulations.

I understand that this consent may be revoked at any time, except to the extent already acted upon by PRC®, and in which case I agree to hold PRC harmless, by giving notice to PRC. I understand that treatment at PRC may not be conditioned upon my signing this consent. Unless previously revoked by me, this consent shall expire one year after the date listed below.

I am entitled to a copy of this authorization upon request.

Signed this _____ day of _____, 20_____

Client Signature

Witness

We must have this signed, completed PRC® form to release information to or communicate with others. To protect confidentiality, other forms of authorization will not be honored.