PROFESSIONAL RENEWAL CENTER®
Authorization to Exchange 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:

Exchange information with

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
2._____ Drug Testing
3._____ Diagnosis
4._____ Evaluation Recommendations
5._____ Evaluation Summary for Facility
6._____ Assessment Discharge Summary
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):_____
13.____Treatment Plan
14.____Treatment Status Updates- Verbal and/or Written
15.____Treatment Discharge Summary
16.____Fitness for Duty Letter
17.____Aftercare Agreement
18.____Prognosis

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.

1421 Research Park Drive, Suite 3B, Lawrence, KS 66049
Phone 785-842-9772 Fax 785-842-5231 www.prckansas.org (REV 12/12)