

**PROFESSIONAL RENEWAL CENTER®  
Authorization to Obtain Information**

Patient Name (please print) \_\_\_\_\_  
Other Names Used at PRC®, 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  
**OBTAIN** information from:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Company: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

1. \_\_\_ Personal Life Data
2. \_\_\_ Reason(s)/Concern(s) Leading to Referral
3. \_\_\_ Data on my functioning in the ABMS/ACGME 6 core competency areas
4. \_\_\_ Other (please specify): \_\_\_\_\_

The purpose of the authorization is for: \_\_\_ Professional Development \_\_\_ Other: \_\_\_\_\_

I understand that it is the policy of the Professional Renewal Center®, and its employees, agents or consultants to obtain 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 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.***