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.

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