

**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  | 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.***