

Patient Name:

Date of Birth:

Address:

Email:

I authorize Aris Clinic to Release Receive confidential information regarding the above-named patient to/from:

Name: Address:

Phone: Fax: Email: Relationship:

Name: Address:

Phone: Fax: Email: Relationship:

Name: Address:

Phone: Fax: Email: Relationship:

Provide information via: Written Fax Telephone Email

Information to be Released (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Family Participation | <input type="checkbox"/> Acknowledgement of Client's Access of Service |
| <input type="checkbox"/> Comprehensive Needs Assessment | <input type="checkbox"/> Alcohol/Drug Abuse Evaluation/Treatment |
| <input type="checkbox"/> Treatment Plans/Recommendations | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Information re: HIV/AIDS status | <input type="checkbox"/> Other: _____ |

This Authorization remains in effect for one year from date signed, or:
(Specify date, event, or conditions that cause authorization to expire)

I understand that I may revoke this authorization at anytime except to the extent that action has been taken in reliance on it. Refer to Aris Clinic's Notice of Privacy Practices for instructions regarding how to revoke authorizations or to inspect or receive copies of this information. A photocopy/fax of this authorization will be treated in the same way as the original. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand.

I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits or payment status.

I understand that once information is released, as authorized by this form, Aris Clinic, its employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

Signature of Patient _____ Date _____ Signature of Parent /Guardian _____ Date _____

Relationship to Patient _____

Office use only: Records released by: _____ Date: _____ MRN _____