Authorization to Disclose or Release
Mental Health or Substance Abuse Treatment Information

I, _____, whose Date of Birth is _____, authorize Acceptance in Abundance LLC to disclose to and/or obtain from: _____ located at _____the following information:

Description of Information to be Disclosed or Released (Patient should check each item to be disclosed)

_____ Assessment
_____ Psychosocial Evaluation
_____ Psychiatric Evaluation
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Toxicological Reports/Drug Screens
_____Discharge/Transfer Summary
_____ Progress in Treatment
_____Other_____

_____ Diagnosis
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Medication Management Information
_____Nursing/Medical Information
_____ Educational Information
_____ Continuing Care Plan
_____ Demographic Information
_____Other_____

Purpose
The purpose of this disclosure or request of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than as stated above, please specify:
_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Acceptance in Abundance LLC at 310 Tolbert Dr. Greenwood SC, 29649 Attn: Deshandra Johnson. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated _____.
A copy of this form will be maintained for a period of five (5) years from this expiration date.

Conditions

I further understand that Acceptance in Abundance will not condition my treatment on whether I give authorization for the requested disclosure or Release. However, it has been explained to me that failure to sign this authorization may have the following consequences: Counselor is unable to release or seek collateral information.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records. _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____ _____

Signature of Staff Witness Date