DeNovo Center LLC,

Consent to Release Medical Record Information

I, _____ **(client or guardian name),** hereby authorize DeNovo Center and the following party: _____

(to whom records shall be released).

Facility where treatment was rendered: DeNovo Center, LLC

Name: _____

Relation to Client: _____

Email: _____

Phone: _____

Address: _____

Atttn: _____

and their respective agents, and/or employees, to disclose to and/or obtain from each other copies of any and all information and/or records regarding my psychological and mental diagnosis and treatment and other pertinent information relative to my past, present, or future condition. I realize that the exchange and disclosure of information between each of such parties is for the purpose of assisting all involved in properly treating me and facilitating transition of care.

Please note that the medical records request may take up to 30 days for processing.

Reason:

☐ Continuum of Care (ongoing treatment)

☐ Disability

☐ Litigation

☐ Personal/Other: _____

Please release the following: (check all that apply)

☐ Assessments

☐ Clinical Notes

☐ Treatment Plan

☐ Discharge Summary

☐ Aftercare Recommendations

☐ All documents listed above

☐ Other (please list): _____

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I may also request that only specific information is communicated. Furthermore, I understand that I may revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the applicable parties named herein. I understand that the revocation will not apply to information which has already been released in response to prior authorization.

Additionally, I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. Please find the HIPAA website and their policy concerning medical records.

http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/medicalrecords.html

This authorization expires automatically one (1) year from the date signed

(start date: ,end date:) unless designated otherwise. I have received a copy of the signed authorization.