Roots to Recovery Collective, LLC

Release of Information & Consent to Exchange Record

Client Name: _____ Date of Birth: _____

Phone: _____

I authorize Roots2Recovery Collective to: ☐ Release ☐ Obtain ☐ Exchange Information

With/To/From: _____

Agency/Address: _____

Phone: _____ Fax: _____

Purpose of Disclosure (check all that apply):

☐ Coordination of care ☐ Treatment planning ☐ Case management

☐ Legal/Probation requirements ☐ Other: _____

Information to be Shared (check all that apply):

☐ Attendance & participation in services

☐ Treatment plans & progress notes ☐ Substance use history ☐ Discharge summary

☐ Mental health history ☐ Medications ☐ Other: _____

Expiration of Authorization

☐ On this date: _____ ☐ One year from date signed

☐ Upon completion of treatment ☐ Other: _____

Your records are protected by federal confidentiality rules (42 CFR Part 2 and HIPAA). They cannot be disclosed without your written consent, unless otherwise permitted by law. If you authorize this disclosure, the information may not be re-disclosed by the recipient without your permission, unless allowed by law. You may revoke this consent at any time in writing, except to the extent that action has already been taken based on it

Client Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

Witness/Staff Signature: _____ Date: _____