SAGE
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Release of Information

This release is in compliance with federal regulations (42 CFR Part 2) and with all applicable state and local laws, rules and regulations. Information may not be further disclosed without permission from the client and may not be used criminally to investigate or prosecute any substance abuse client. I understand that my consent is made voluntarily, and I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke any written consent at any time in any event; this consent expires automatically in one (1) year from the date of signature. I understand that once the information is released, the information may no longer be protected.

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

Revocation: I understand that I may revoke this authorization, by requesting in writing, a discontinuation of this document to **7004 Bee Caves Rd, 2-200, Austin, Texas 78746**. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. 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.

I, _____, consent to the release of privileged information and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation, and authorize Sage Recovery & Wellness Center's staff to communicate with the individuals listed below to exchange any information for the purpose of clarifying and enhancing my care and treatment.

Please check one or both of the following: **To obtain from ☐** **To disclose to ☐**

Name or Agency:_____ Relationship:_____

Phone: _____ Fax: _____

Please check at least one of the following to indicate what information you would like released to the above individual.

☐ Biopsychosocial Assessment ☐ Treatment Plans ☐ Medical History/ Current Status ☐ Legal Status	☐ Presence in Treatment ☐ Letter of Completion ☐ Laboratory Test Results ☐ Progress Notes	☐ Urinalysis Results ☐ Group Notes ☐ Individual Therapy Notes ☐ FMLA or Disability Paperwork	☐ Discharge Summary/Aftercare Recommendations ☐ Financials and Attendance ☐ Psychiatric History & Assessment/ Evaluation ☐ Progress Updates ☐ Other: _____

Sage Recovery & Wellness Center, and others listed above, are hereby released from all liability arising out of, or in any way incidental to, producing records or providing information according to this authorization.

A duplicate, photocopy or facsimile reproduction of this document may be used in lieu of the original.

This authorization is subject to revocation in writing by the undersigned.

Client Signature_____Date_____

Witness Signature _____