SAGE
RECOVERY & WELLNESS CENTER

Release of Information

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

Expiration: Unless sooner revoked, this authorization expires on the 60 days after my last appointment.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the therapist I am working with at **Sage Recovery & Wellness Center**. 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, _____ (parent/guardian), consent to the release of privileged information for _____ (patient) 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:_____ Relationship to Client:_____

Phone: _____ Fax: _____

**Ask the front desk staff for another copy of this form if you would like to or are required to release privileged information to more than one individual.*

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

☐ Assessment	☐ Discharge Summary	☐ Individual Therapy Notes
☐ Master Treatment Plan	☐ Homework Assignments	☐ Financials
☐ Treatment Plan Updates	☐ Group Notes	☐ Labs

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_____

Parent/Guardian Signature_____Date_____

Witness Signature _____