

## 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, \_\_\_\_\_, 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: \_\_\_\_\_ 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.**

<input type="checkbox"/> Assessment <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Letter of Admission	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Letter of Completion	<input type="checkbox"/> Urine Analysis <input type="checkbox"/> Group Notes <input type="checkbox"/> Individual Therapy Notes	<input type="checkbox"/> Attendance <input type="checkbox"/> Financials <input type="checkbox"/> Other: _____
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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 \_\_\_\_\_