EMPOWER PSYCH CENTERS – Dr. Richard Gestring

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(314) 200-2628 *phone* (314) 200-2628 *fax*

CONSENT FOR RELEASE OF CLIENT INFORMATION

Name: _____ DOB: _____

I hereby authorize **Empower Psych Centers** to obtain and release specified information in my medical record for continued medical care.

Individual or Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

This information shall include the available items checked below:

- ○ Admission Summary
- ○ Discharge Summary
- ○ Progress/Treatment Notes
- ○ Initial Evaluation
- ○ Medication Records
- ○ Laboratory Results
- ○ Psychological Testing
- ○ Other _____

Dates of Treatment: *From:* _____ *To:* _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that this authorization may include disclosure of information relating to *ALCOHOL* and *DRUG TREATMENT, MENTAL HEALTH TREATMENT*, and *CONFIDENTIAL HIV/AIDS-RELATED INFORMATION*. With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. I understand that this disclosure does not expire. I have the right to revoke this authorization at any time by writing to the provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

I have read and understood the above statements and I consent to the release of protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will follow state laws and responsibility of the patient, unless otherwise noted.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____