Addiction Care of Excellence

An Outpatient Medical Recovery Program

Authorization for Release of Information

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Address: _____

☐ **TO ACE:**

I authorize _____ at
(Name of physician or authorized facility)

_____
(Street address)

_____
(Telephone and Fax numbers)

to release to Addiction Care of Excellence (ACE) my medical, psychiatric, HIV, and AIDS-related testing or results and / or substance use information from my medical records.

☐ **FROM ACE:**

I authorize Addiction Care of Excellence (ACE) to release my medical, psychiatric, HIV, and AIDS-related testing or results and / or substance use information from my medical records to

_____ at
(Name of physician or authorized facility)

_____
(Street address)

_____
(Telephone and Fax numbers)

The requested information may be mailed or faxed to ACE. I understand that I may revoke this consent at any time before the information has been released. This consent expires one (1) year from the date below.

Any alcohol or substance use information, HIV or AIDS-related information released is protected by Federal Regulations and may not be re-disclosed without the specific written consent of the undersigned.

Patient Signature: _____ OR

Signature of Legal representative: _____ ___ _____
(Copy of Power of Attorney for Health Care must be attached)

Date: _____