Authorization for Release of Protected Health Information

I, _____ Date of Birth _____,
authorize Pathways To A Better Life LLC to disclose to and/or obtain from:

_____ the following information:
(Name of Person or Title of Person or Organization)

Patient/Client must <u>INITIAL each item</u> to be disclosed.

_____ Assessment
_____ Diagnosis
_____ Psychological Evaluation
_____ Treatment Plan
_____ Discharge Summary
_____ Continuing Care Plan
_____ Current Treatment / Progress Update
_____ Presence / Participation in Treatment
_____ Medication Management Information
_____ Nursing / Medical Information
_____ Toxicology Reports / Drug Screens
_____ Other: _____

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. (This information will NOT be used for marketing purposes, sale of information, or research.)

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Pathways To A Better Life LLC at PO Box 347, Kiel, WI 53042. 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.

This authorization expires one year from the effective date unless revoked earlier.

Expiration Date: _____

This consent, unless revoked earlier, shall be valid for one year and a copy of fax copy of this release will be considered as valid as the original. I understand that reports released may include alcohol/drug abuse and/or psychiatric records. I understand I may revoke this authorization at any time, by providing a signed written statement to Pathways To A Better Life LLC. I realize if I cancel this authorization it will not affect disclosures that have already occurred based on my authorization. I understand that if I agree to sign this authorization, I may receive a copy. I understand that current or future treatment at Pathways To A Better Life LLC will not be conditional upon my signing this authorization except regarding research related to treatment or treatment that is for the sole purpose of creating health information for disclosure to a third party. I understand that I have a right to inspect and receive a copy of the disclosed material. Information disclosed is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. However, I understand that any disclosure of information carries the potential for unauthorized re-disclosure and information may not be protected by Federal privacy standards.

_____ _____
Signature of Patient / Client — Date

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Staff Member for Pathways To A Better Life LLC — Date