CelebrityCare MEDICAL CLINIC

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830-249-8400 Office 830-255-4660 Fax

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____, authorize_____ at the above address to:
Patient Name (Print) Physician Name (Print)

Check all that apply

☐ Receive my medical history information from the following physicians or treatment provider:
(name, address)_____

(name, address)_____

☐ Receive my treatment records from the following therapist:
Therapist (name, address)_____

☐ Release my treatment information/records to the following healthcare professional:
(name, address)_____

☐ Release my treatment information to the following family member, significant other, or close friend:
(name, address) _____

(name, address) _____

This information is for the following purposes (any other use is prohibited): _____

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____	_____
Patient Signature	Patient Name (Print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date