ADVANCED RECOVERY SYSTEMS
an advanced approach to patient care

RELEASE OF INFORMATION

Patient Name:_____ DOB:_____

By signing this consent, I authorize Advanced Recovery Systems, LLC, and each of its affiliated facilities (collectively, "ARS") to exchange my information with the following person or entity ("Recipient"):

Recipient Name: _____

Recipient Email Address: _____

Recipient Fax Number: _____

Recipient Phone Number: _____

Recipient Address: _____

How should this information be sent (electronic/email, fax, oral, mail)?_____

I authorize the exchange of the following information (check all that apply):

- ☐ Presence in Treatment
- ☐ Treatment Plans
- ☐ Biopsychosocial Assessment
- ☐ Therapy Notes
- ☐ Entire Record
- ☐ Other (specify): _____
- ☐ Laboratory Test Results
- ☐ Physician Orders
- ☐ Medication Records
- ☐ Discharge Summary

Please specify requested medical record date range, if applicable: _____

Information/records may include reference to my HIV/AIDS status: ☐ I do **not** want this included

I authorize the exchange of my information for the following purpose:

☐ Legal purpose ☐ Family/friend support
☐ At my request ☐ Other (please specify): _____

Statement of Consent:

I understand that:

- Information exchanged pursuant to this consent may be subject to redisclosure by the recipient of such information and may no longer be protected by applicable privacy laws; however, 42 CFR Part 2 prohibits the recipient from re-disclosing my information except as permitted by law.
- I may revoke this consent in writing at any time by completing the Revocation of Consent Form, available by request at ARS's facilities or by email request to ARS's Medical Records Department at medicalrecords@advancedrecoverysystems.com. The revocation can specify certain individuals or organizations from whom I wish to withhold my Protected Health Information (PHI), and does not affect my general consent for ARS to

use and disclose my PHI for treatment, payment, and healthcare operations with parties not specified in this revocation, except to the extent that ARS or another lawful holder permitted to disclose my information has already acted in reliance on the consent. To ensure proper processing of a revocation request, please submit the completed revocation form either to your primary clinician (or appropriate staff member) or directly to the Medical Records Department.

- ARS will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide consent for the exchange of my information.
- I have the right to receive a copy of this consent.

This consent expires automatically one (1) year from my signature.

_____ _____

Patient Signature **Date**

_____

Patient's Authorized Representative Signature

_____

Authority to act for the Patient

If the patient revokes this consent at any time, date of revocation: _____