Ardent Center for Excellence

(The Center for Life Enrichment)

Authorization to Release Information

_____ I authorize Ardent to request records from the following office:

_____ I authorize Ardent to release records to the following office:

_____ I give Ardent permission to speak verbally with the following individual/office:

_____

(Name of Facility or Clinician)/Nature or Relationship to Patient

_____ _____

(Address) (City, State, Zip)

_____ _____

(Phone Number) (Fax Number)

The following information on _____ _____

(Patient's Name) **(Date of Birth)**

Please release the following information (or specify):

___ Verbal Information
___ Medical Records
___ Medical History/Physical
___ Psychologist Evaluation
___ Social History
___ ALL INFORMATION
___ Lab Results
___ Treatment Plan/Patient Progress
___ Discharge Summary
___ Results of Drug and Alcohol Treatment or Testing
___ Other (specify) _____

For the Purpose of: _____

Approximate Dates of Service: _____

Release Expiration Date: _____ ***Not to exceed 90 days*** (Consent subject to revocation at any time.)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed authorization form showing when my records have been sent.

_____ _____

Signature of Patient / Responsible Party if Minor Date

_____ _____

Signature of Witness Date

_____ _____

Signature of Clinician #1 Date

_____ _____

Signature of Clinician #2 Date

_____ _____

Signature of Clinician #3 Date

_____ _____

Date Records Sent: Initials of Records Keeper

**** There is a standard processing fee of $30.00 for any medical records that are released outside of physician offices. Also, all patient responsibility balances must be paid in full before any medical records are released. ****