CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I ____ authorize Pinnacle Rehabilitation Group to:

I hereby authorize and request Pinnacle Rehabilitation Group and its employees to ***RELEASE*** my protected health medical records, including but not limited to drug screen results, financial information, appointment history, and any & all information to:

1.) ____
2.) ____
3.) ____
4.) ____

REQUEST RECORDS FORM:

I hereby authorize and request Pinnacle Rehabilitation Group and its employees to ***REQUEST*** my protected health information from:

1.) ____
2.) ____
3.) ____
4.) ____
5.) ____

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 in 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 will contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records will 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 Date