Authorization for Release of Information

I, ____, date of birth ______________________

hereby authorize Women for Recovery/Serenity Grove to release/obtain (circle one or both) my protected health information including my current functioning, past assessments/history of treatment/discharge/release paperwork to/from:

Person: ____

Agency ____

Address ____

Phone _______________________ Fax _____________________

This Authorization includes:

× a.) release of records relating to treatment for mental health/addictions/HIV, AIDS and AIDS related illnesses/Hepatitis C/and/or treatment of any other communicable diseases.

× b.) Other____

The purpose of disclosure is assisting in continued abstinence.

This authorization will continue in effect: × from today's date and for the duration of my residency at, and 1 week past the date of my official departure from Serenity Grove. × Other _______________________

The above information will not be disclosed without a signed written release.

This authorization may be revoked at any time with a written notification to The Serenity Grove House Administrator/Recovery Coordinator or the President of the Board of Women for Recovery with the exception of information that has already been released.

Signature ____ Date __________________

Witness ____ Date __________________

Adopted: 4/12/18