Healing Arts, LLC
1130 Ten Rod Rd., Building F Suite 207
North Kingstown, RI 02852
401-932-6820

Written Authorization For Release of Information

Name of Client: _____ Phone: _____

Date of Birth: _____

I do hereby authorize: Healing Arts, LLC

To disclose to: _____

Phone:_____

Address:_____.

_____

The Following Information:

Y { } N { } Discharge Summary/Aftercare Plan

Y { } N { } History and Physical Examination

Y { } N { } Psychosocial Assessment

Y { } N { } Client's Progress

Y { } N {X} Psychotherapy Notes

Y { } N { } Consultation

Y { } N { } Verification of Treatment

Y {) N{ } Toxicology/BAC Results

Y { } N { } DOT SAP Evaluation

Y { } N { } Other (Specify)_____

Purpose of Disclosure: { } Continuity of Care { }Medical { } Legal { } DOT/SAP Evaluation: Return to Duty

Please **initial** either "Yes" or "No" regarding release of information regarding HIV/AIDS { }Yes { } No

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I understand that except in limited circumstances Healing Arts, LLC will not condition my treatment on whether I give authorization for the requested disclosure.

I am fully aware that the following information which I am authorizing Healing Arts, LLC to receive or send may be drug or alcohol related information protected under 42 C.F.R Part 2 and/or information regarding sexually transmitted diseases. Federal Law prohibits the person or organization to whom disclosure is made from making any further disclosures this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

I am aware that I may withdraw my consent at any time except to the extent that action has been taken on this statement in reliance on this statement of informed consent. I also understand that if even I do not withdraw this consent, this statement of consent shall expire automatically on _____ or twelve (12) months.

Signature of Client, Parent, Guardian or Legal Representative: _____

Signature of Witness: _____

Date: _____