ACHIEVE WHOLE RECOVERY
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Colorado Springs, CO 80907
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AUTHORIZATION TO RELEASE AND OBTAIN MEDICAL INFORMATION ON

_____ whose date of birth is _____ for

NAME	TITLE	
ADDRESS		
CITY	STATE	ZIP CODE
PHONE	FAX	

The following information, including drug and alcohol treatment records, both verbal and written, for dates of service from _____ to _____.

Information to be released:

☐ Discharge Summary ☐ Admission Summary ☐ Progress Notes
☐ Laboratory Results ☐ Psychological Testing and/or Report
☐ Other: _____

Purpose for this release: ☐ Continuity of Medical Care ☐ Claim Information ☐ Legal ☐ Personal Use
☐ Other: _____

Revocation: I understand I have the right to revoke this authorization at any time, except to the extent that it has already been acted on.
Expiration: This release will expire one year from the date signed unless I provide notice sooner.
Conditions: I understand that Dr. Snyder may condition my care and treatment on whether I give authorization for the requested information deemed reasonably necessary to provide quality care and treatment.
Redisclosure: Federal Law (42 CFR Part 2) prohibits any further disclosure of this information without written authorization or as otherwise permitted by 42 CFR Part 2.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Staff Signature Date