FRESH START MEDICINE
Where Your Recovery Begins

HIPAA Release of Confidential Information

Patient Information:

Patient Name: _____

Date of Birth:_____

Information to be Disclosed:

I _____, authorize the disclosure of my confidential health information relating to my treatment at Fresh Start Medicine.

(CHECK ALL THAT APPLY)

_____MAT ____PRIMARY CARE _____All information.

Recipient of Information: This information is to be disclosed to:

Recipient's Name: _____

Relationship to Patient: _____

Phone Number: _____

Purpose of Disclosure: The purpose of this disclosure is to facilitate communication and involvement of my the above named individual in my treatment and support related to my health condition.

Extent of Information: This release includes, but is not limited to, information regarding my diagnosis, treatment, medications, and any other information pertinent to my health condition and treatment at New Life Medicine.

Duration of Authorization: This authorization shall remain in effect until I submit in writing to discontinue the disclosure.

HIPAA Notice:

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy regulations.

Patient Signature: _____**Date:** _____

Witness Signature: _____**Date**_____