RELEASE OF INFORMATION

Room 2 Grow, LLC
7500 Brooktree Rd. Ste 201
Wexford, PA
Phone: 412.525.6594

PATIENT NAME: _____
BIRTHDATE: _____

I have been a patient at Room 2 Grow, LLC or I am the patient's authorized representative. I understand that this facility has legally protected health information about me or the person that I represent. I understand that signing this form will not affect the treatment that I receive in any way. This authorization expires 1 year after the date signed, but I have the right to revoke this release at any time by sending a written request to the facility I have authorized to release the information.

I, _____, hereby authorize Room 2 Grow, LLC to
❑ obtain from and/or
❑ release to:
Name of Facility:_____
Attention:_____
Address: _____
City, State, Zip code: _____
❑ I give permission to fax to number: _____ ATTN:_____

Information Authorized for Release:

☐ Psychotherapy Intake Assessment	☐ Treatment Attendance	☐ Report to Satisfy Court Ordered Request	☐ Other:
☐ Psychotherapy Treatment Record	☐ Letter / Report Re: Treatment	☐ Hospital Admission, Stay, Discharge	☐ Other:

From (date)_____ to (date) _____
Purpose of Request: ❑Continuity of Care ❑ Other (specify)_____

I release the above entity that disclosed this information from any legal responsibility or liability for disclosure of the above information to the extent that the information was used for its stated purposes. Information used by or disclosed to other organizations pursuant to this authorization may no longer be protected by our Privacy Rule, but further disclosure by organizations other than Room 2 Grow, LLC requires my additional signed release.
I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation.
I understand that I may revoke this consent verbally or in writing at any time except to the extent that the action has been taken in reliance on it. This authorization expires one year from date of signature, unless otherwise stated. Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including but not limited to, written or electronic format.
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information without written authorization from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Signature _____ Date _____
(Patient aged 18 years or older OR Parent/Guardian of a minor child)
Signature _____ Date _____
(Signature of patient 14-17 years of age)
Signature_____Date_____