Sterling Behavioral Health Services, LTD

CONSENT TO RELEASE OF INFORMATION

Communication between healthcare providers and/or among family members is important to help ensure that you receive comprehensive and quality care; however, your information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and/or medication history. You may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it.

I, _____, for the purpose of coordinating care, authorize
(Client Name)

_____ to release and/or exchange the information indicated below to
(Provider Name)

_____ _____ _____
(Recipient Name) (Fax) (Mailing Address or Email)

I/we, the undersigned, understand that I/we may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it. I/we have read and understand the above information and give my/our consent.

Please indicate the information you authorize for release to the above-named party:

[ ] Any applicable mental health/substance abuse information

[ ] Only medical information

[ ] Other: _____

[ ] None

_____ _____ _____ _____
Client Signature Date Parent/Guardian Signature Date
(Required for clients under the age of 18)

Notice to Recipient of This Information: This information has been disclosed to you from records which are protected by Federal (42 CFR Part 2) and State laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person of whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.