Produce Opportunities Which Embrace Rehabilitation, (POWER) LLC

Private Practice - Virtual Office Location

Tel. (410)240 – 4174; Email: powerprivatepracticellc@gmail.com

Request/Authorization for Release of Client Information

I (first name & last name) _____, (DOB/MM/DD/YYYY)_____ hereby authorize the release of the following information to be disclosed and released to and from Produce Opportunities Which Embrace Rehabilitation, (POWER) LLC., and Name/Title: Noelle Johnson, LCPC_ Business Phone: (410)240–4174; Facility Address: _____ .

Types of information to be disclosed: Please indicate the type of document by checking it.

☐ Mental Health history & progress ☐ Medical & Substance use history & progress

☐ Infectious Diseases (HIV/AIDS & related info.) ☐ Drug Screens/Urinalysis

☐ Dose Verification ☐ Emergency Contact ☐ Discharge/Transfer Summary

☐ Treatment Summary & progress ☐ Recommendations/Prognosis ☐ Physical Exam

☐ Counseling Notes ☐Other _____

The purpose of this disclosure is to: ☒Coordination of Treatment; ☐Locating the client/receiving/sending messages ☐ Complying with Parole/Probation/DSS ☐ Emergency contact information ☐Other: _____

☐ PLEASE **DO NOT** FAX INFORMATION, NOT NEEDED AT THIS TIME **OR**

☐ PLEASE FAX INFORMATION AT THIS TIME

Method of release: ☐ Verbal Phone and/or ☐ Fax ☐ Email ☐ U.S. Postal Mail ☐ Any of these methods

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THIS PROGRAM HAS ALREADY TAKEN RELIANCE ON IT. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE WITHIN (CHECK ONE): ☐ ONE (1) YEAR (DEFAULT): ☐ TWO (2) YEARS; ☐ OTHER: _____

TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records protected by Federal Confidentiality Rule (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written agreement with the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the attached information to criminally investigate or prosecute any substance use disorder client.

Client Signature Date

Witness Signature Date

This client information release authorization is prepared in accordance with the authority specified in Public Act 56 of 1973. This form is in compliance with Title 42 of the Code of Federal Regulations Part 2.

Revocation of Consent

I, _____ , hereby revoke this consent to release information.

Client Signature Date

Witness Signature Date

Form: Revised 09/14/2023