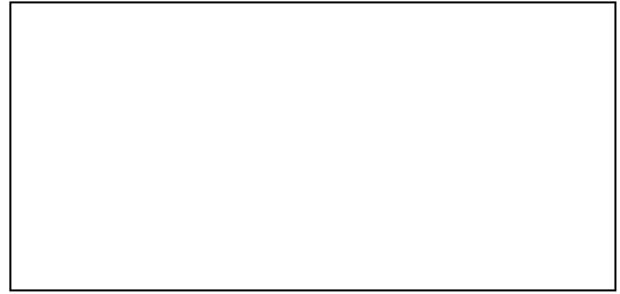

MRN:______________________________

Name:______________________________

DOB:_________________

AUTHORIZATION TO RELEASE INFORMATION TO SOBER RESIDENCES

By my signature below, I hereby authorize Bournewood Hospital to release information about me to sober living residences for the purpose of identifying sober housing for me during my participation in the Hospital's Partial Hospitalization Program. I understand that this information will include my identifying information and that I am receiving treatment for drug and/or alcohol abuse as part of the Hospital's Partial Hospitalization Program. I understand that this Authorization to release information will remain in effect until this Authorization expires, or I provide a written notice of revocation to Bournewood Hospital. The revocation will be effective immediately upon Bournewood Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Bournewood Hospital before it received my written notice of revocation. I understand that federal privacy law may no longer protect the information furnished after it is released.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason, and that such refusal or revocation will not affect the commencement, continuation, or quality of Bournewood Hospital's treatment of me. I hereby release Bournewood Hospital from all legal responsibility or liability that may arise from the release of this information or re-disclosure by the recipient(s). This Authorization will remain in effect for 90 days or such other time as I may specify in writing

Date: _________________

Signature of Patient: ____________________________________

Date: _________________

Witness: ____

To Be Filed in the Medical Record