SACRED HEART REHABILITATION CENTER, INC.
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, (D.O.B._____) authorize Sacred Heart Rehabilitation Center, Inc. to

_____release _____exchange
(Client must initial release and/or exchange)

information contained in my records to the person or organization listed below.

1. **Name of person(s) or organization(s) to whom disclosure is to be released/exchanged:**

RECORDS DEPOSITION SERVICE, INC.

PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248.357.3330 F: 248.357.3337

2. **Specific type of information to be disclosed (Verbal, Written, or Electronic):**
(Client must initial approved information)

____Bio-Psycho-Social Assessment
____History & Physical
____Treatment Plan
____Diagnosis, Attendance, Progress, & Prognosis
____Dates of Treatment
____Medication Information
____Tuberculosis Test
____Physicians Orders
____Continuum of Care
____Verification of Methadone
____Urine Drug Screen
____Insurance Information
____Other:_____

3. **The purpose and need for information:**
(Client must initial approved purpose)

____Billing Eligibility / Validating the Appropriateness of Service Delivery
____Legal
____Employment
____Family Involvement
____Coordinate Treatment Services
____Continuation of Care
____Follow-Up Medical Care
XX Other: **PRE-TRIAL DISCOVERY**

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Unless revoked this consent will expire one year from the date signed.

_____ _____
Client's Signature Date

_____ _____
Witness Date

pn/4-05