FAMILY RENEWED
Dawn M. Porter, MD

Patient Last Name, First Initial

Authorization for Release of Health and/or Educational Information (Including Alcohol/Drug Treatment and Mental Health Treatment) (pg. 1 of 2)

Patient Name and DOB	Patient Address

I,_____, request that health and/or education information regarding my or my child's care and treatment be released to/from Dawn M. Porter, MD of Family Renewed, LLC 3636 S. Geyer Road, Suite 100, St. Louis, Missouri 63127 or 1670 Essex Way, O'Fallon, IL 62269, as set forth on this form.

I further acknowledge that I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my initials on the appropriate line in item 5.

In the event the health information described below includes any of these types of information mentioned above, I will initial the space on the appropriate line in item 5, and specifically authorize release of such information between Dawn M. Porter, MD of Family Renewed, LLC and the person(s) indicated in Item 3.

1. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 3. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

2. Signing this authorization is voluntary. I understand that generally my treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

3. Name, Address and Phone of Person(s) to/from whom this information will be disclosed:

_____

_____

_____

4. Purpose for Release of Information:

_____

_____

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5. Unless previously revoked by me, the specific information below may be disclosed for a period of one year from today's date unless specified here.

From:_____(start date) until_____(expiration date).

All health or educational information (written and oral may be released between the parties specified above), except:

_____

For the following to be included in the release, indicate the specific information to be disclosed and initial in the space provided.

_____ Mental Health Clinical records/information
_____ Records from alcohol/drug treatment programs
_____ HIV/AIDS related information to be disclosed

6. All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT (If patient is 13 years or older) DATE

_____ _____
SIGNATURE OF GUARDIAN (include relationship) DATE

_____ _____
SIGNATURE OF WITNESS DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

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