RUTTENBERG AUTISM CENTER

1740 Walton Road, Suite 100
Blue Bell, PA 19422
Phone: 484.567.4725
Fax: 610.397.0990
www.Ruttenberg.com

CONSENT TO RELEASE AND RECEIVE SPECIFIC INFORMATION

This Consent authorizes The Ruttenberg Autism Center:

Release Information/Records: **Patient's Initial's: _____**
Receive Information/Records: **Patient's Initial's: _____**

Patient: _____ **DOB:_____**

Name: (Facility/Agency/Person & relationship to Patient)

_____

Telephone: _____

Email: _____

Address: _____

The following information I have specifically initialed:

Patient's Initials = Consent; Patient's Initials = N/C = Consent

- ☐ Medical records regarding chemical dependence (history and physical examination, Laboratory results, medical discharge summary)
- ☐ Social assessment
- ☐ Discharge summary, Aftercare Plan Reason for discharge
- ☐ Treatment Issues or Concerns
- ☐ General Progress
- ☐ Sponsor verification
- ☐ Emergency Contact
- ☐ Financial (Guarantor/Insurance)
- ☐ Referent (Person who referred you to the Ruttenberg Autism Center)
- ☐ Other _____

In signing this consent, I do so with the understanding that this form acts as a waiver of any claim I might assert against the Ruttenberg Autism Center for the release of this information. This consent is subject to revocation in writing at any time; otherwise it will **expire 90 days after the signature date,** or after the requested information has been provided, whichever comes first.

This information shall be kept confidential and will not be released to any other agencies, persons or facilities according to the Federal Confidentiality Regulations. This information has been disclosed to you from records whose confidentiality is protected by federal law. "Federal Regulations Title 42 C. F. R., Part 2, prohibits RAC from making any further disclosure of this information, except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose."

Expiration Date: [365 days from date] _____

Patient Signature: _____ **Date: _____**

Relationship to Patient: _____

Witness Signature: _____ **Date: _____**