

**SPENCER RECOVERY CENTERS
CONSENT TO RELEASE INFORMATION
FROM HEALTH/HOSPITAL RECORDS**

- 1) I, _____, hereby authorize
Name of client
(For identification please provide the last 4 digits of your SS# _____ and your
birth date _____.)

Please check facility location(s) that apply:

- _____ 1316 S. Coast Hwy, Laguna Beach, CA 92651
_____ 1276 N. Palm Canyon, Palm Springs, CA 92262
_____ 140 Corey Ave., St Pete Beach, FL 33706

to disclose information from my health/hospital records which was obtained during my
diagnosis and treatment at this facility to:

- 2) _____
Name of person/facility to receive records

Address of person/facility to receive records

- 3) The disclosure of these records is required for the purpose of:

- 4) This disclosure is limited to the following **specific** types of information:

- 5) This consent will become effective immediately. If it is not revoked earlier, it will remain
in effect for one year from the date of signature.

- 6) I am fully aware that certain State and Federal Regulations protect the confidentiality of
the information in these records.* These regulations also require that I voluntarily and
knowingly sign this document before Spencer Recovery Centers, Inc. can release
any record, and that I may refuse to sign my signature, in which event the records
cannot and will not be released by the above named person/facility.

*This consent includes all records of psychiatric and/or substance abuse diagnoses,
examinations, treatments, prognosis, counseling, and/or therapy which may be subject to the
confidentiality requirements of Section 5328 of the California Welfare and Institutions Code
and/or 42 C.F.R., Part 2, Federal Register.

- 7) I understand that my information may not be re-disclosed by the recipient without my
further written authorization unless otherwise provided for by state or federal law.

Client Signature

Date

Signature of parent or authorized representative if required

Date