ANDREWS CENTER
CONSENT FOR FAMILY/PHYSICIAN RELEASE

I,

Name	DOB	Case #	Effective Until

Give my permission to and hereby authorize Andrews Center Personnel to discuss my treatment at Andrews Center with my family member(s) listed below for the purpose of involving them in my treatment:

Name Relationship

Name Relationship

This permission includes the release of verbal information concerning the following: my diagnosis, my care/treatment *(including any treatment for drug, alcohol or HIV/AIDS), my medications, prognosis, or appointments.*

I request the following l imitation:

☐ *I do not want my family involved with my treatment or verbal information concerning my illness/disability and my treatment at Andrews Center released to my family member(s).*

I authorize the Andrews Center to release/obtain information regarding my treatment and/or changes in treatment to/from:

Name

Address

City, State, Zip

☐ **PRIMARY** Care Physician

☐ Attending Physician

☐ Other

☐ ***I DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION TO MY PRIMARY CARE PHYSICIAN OR OTHER PHYSICIAN.***

This permission is given for 180 days from the date of signature or the time period specified above. I understand that I may revoke my permission in writing at any time with the exception that the information has not been previously released. I further waive and release Andrews Center from liability resulting from the release of the above information.

SIGNATURE____ DATE__________________

WITNESS____ DATE__________________

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Revocation of Consent

I, , hereby revoke or cancel this authorization effective (Date).

____ __________________________

Witness Date

A PHOTOCOPY OR FACSIMILE IS AS VALID AS THE ORIGINAL

CMHMR-322-5/98; 10/2022