Wayside
RECOVERY CENTER

RECORDS REQUEST (for patient use)

Women's Treatment Center: 952-926-5626 | Fax: 952-926-9713
Family Treatment Center: 612-871-0099 | Fax: 612-871-0929
Wellness Center: 651-242-5540 | Fax: 651-209-6341

CLIENT INFORMATION

Name_____ DOB_____

Address_____

Phone_____ Email (optional) _____

REQUESTING THAT RECORDS BE SENT TO:

Organization and/or person name_____

Address_____

Please indicate how records should be sent:

☐ Phone_____ ☐ Fax_____ ☐ Email_____

Information needed by date of _____

I authorize the Wayside Recovery Center to receive and release information from or to the person, agency or facility named, either verbally or in writing, as indicated in this authorization.

RECORDS TO BE RELEASED:

- ☐ Entire record
- ☐ Psychiatric assessment
- ☐ Admission(s) documentation
- ☐ Diagnostic assessment
- ☐ Other (please specify):
- ☐ Chemical dependency program history
- ☐ Medical records including physical exam
- ☐ Medication records

PURPOSE FOR AUTHORIZATION

- ☐ Coordinate care or discharge
- ☐ Facilitate billing, insurance or other benefits
- ☐ At request of patient or patient representative
- ☐ Other (please specify):

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A copy of this authorization shall be considered as valid as the original.

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I understand that authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to obtain treatment or services from Wayside. However, lack of ability to share or obtain information may prevent Wayside Recovery Center from providing appropriate and necessary care. I may revoke this consent in writing at any time. If I revoke this authorization, I must do so in writing and present it to Wayside Recovery Center at any location. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either:

in one year from the date of this signature

OR upon a specific date (from _____ to _____)

The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the above information is disclosed to a person, facility or agency outside Wayside, the recipient may re-disclose it and the information may not be protected by federal or state privacy laws or regulations.

_____

Signature of Client/Participant **Date**

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

_____

Signature of Guardian/Authorized Representative (if needed) Date

_____

Signature of Witness Date