INNOVATIVE MEDICINE SUBOXONE CLINIC

3554 Promenade Pkwy, Suite H, Lafayette, IN 47909
Phone: 765-471-1100 Fax: 765-471-1009

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I_____ authorize C. Turner, M.D. at the above address to:
Patient Name (print)

release and /or receive my medical history information from the following physicians, family, friends, therapists, hospitals, institutions, and/or organizations:

(name, address, phone) _____

(name, address, phone) _____

(name, address, phone) _____

(name, address, phone) _____

(name, address, phone) _____

I understand that I may withdraw this consent at any time, either verbally or I writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable disease including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date