ASCEND POLYWELLNESS CENTER, LLC
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
PLEASE READ FORM CAREFULLY AND FILL OUT COMPLETELY

___Mail___Pickup___Fax

Clients Name: _____ DOB: _____

1. I authorize

_____ _
Name of Sending Person/Organization
_____
Street Address
_____
City State Zip
_____
Telephone Number
_____
Fax Number

2. To Release To:
Ascend Polywellness Center, LLC

Name of Receiving Person/Organization
7630 Little River Turnpike _____
Street Address
Annandale VA 22003 _____
City State Zip
(571) 478- 1422 _____
Telephone Number
_____
Fax Number

I freely give my consent to Ascend Polywellness Center, LLC and the addressee to exchange information presented below. I understand that my/my child's records are protected under Federal Law Regulations and cannot be disclosed without my written consent unless otherwise permitted in accordance with Federal Law Regulations. The purpose of this release is to provide continuity of care and to assist APWC and the addressee in planning and providing services to me/my child. In no way will this information be used to discriminate against me/my child or deny me/my child services. This release shall remain in effect until the time I revoke this release or until one year after me/my child's last date of treatment. I may revoke or cancel this consent of release by notifying the Privacy Officer of Ascend Polywellness Center, LLC and addressee.
_____ A verbal exchange between Ascend Polywellness Center, LLC and addressee

Addressee to Release
__Demographic Information
__Intake Assessment
__Psychiatric Evaluation
__Medication Log
__Individual Treatment Plan
__Treatment Plan/Reviews
__Other_____

APWC to Release
__Demographic Information
__Social Assessment/History
__Treatment Plan/Reviews
__Medication Record
__Individual Treatment Plan
__Transfer/Discharge Summary
__Other_____

Other Instructions/Notes: _____

_____ _____
Client/Guardian Signature Date