PACIFIC RECOVERY RETREAT

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT CONTACT INFORMATION

Full Name: _____

Date of Birth: _____ **Phone:** _____

Address: _____

Email Address: _____

SECTION B: CONSENT & PRIVACY ACKNOWLEDGMENT

Purpose of Consent

I authorize Pacific Recovery Retreat to collect, use, and disclose my health information as reasonably necessary to coordinate and provide the concierge nursing services I have requested, process payments, and communicate with my designated healthcare providers when appropriate and authorized.

Privacy Practices

I acknowledge that I have been given the opportunity to review Pacific Recovery Retreat's applicable privacy practices and understand how my information may be collected, used, stored, and disclosed, subject to applicable law.

Communication Authorization

I authorize Pacific Recovery Retreat to contact me regarding appointments, services, billing, and recovery-related care using the contact information I provided. I understand that electronic communications, including text messages and email, may carry privacy risks.

Please initial your preferred communication methods:

- **Voicemail:** _____
- **Text messages:** _____
- **Email:** _____

Right to Withdraw Authorization

I understand that I may withdraw an authorization in writing, subject to applicable law. Withdrawal does not affect actions already taken in reliance on the authorization before it was received. Any limitations on services resulting from withdrawal will be explained to me as appropriate.

SECTION C: CLIENT ACKNOWLEDGMENT & SIGNATURE

I confirm that I have read and understood this form, had the opportunity to ask questions, and voluntarily consent to the uses and disclosures described above.

Client Name: _____

Client Signature: _____ **Date:** _____

PERSONAL REPRESENTATIVE (IF APPLICABLE)

Representative's Name: _____

Relationship to Client: _____

Signature: _____ Date: _____