Grace Place Properties, Inc.
Consent for the Release of Medical & Psychological Information

I, ________________________________, give any physician, psychiatrist, psychologist, therapist, treatment center, hospital, clinic, dentist or other medical provider ("Medical Providers") that I see for evaluation or treatment, my consent to release to representatives of Grace Place Properties ("GPP"), information regarding my treatment, my treatment plan, my prescribed medications and my use of those medications, my compliance with any treatment or treatment plan for me, as it may be modified from time to time, or the treatment plan for me established by another Medical Provider, and my use or suspected use of alcohol or illegal drugs or misuse of prescription drugs. In this regard, you may, and I request that you do, provide GPP with periodic reports as requested, and a report at such other time that you deem appropriate, setting forth information about my treatment, my treatment plan and whether I am complying with my treatment plan, including:

1. Whether I am cooperating and participating in my treatment;
2. Whether I am following any required treatment plan.
3. Any modifications to my treatment plan.
4. Whether I am scheduling and attending appointments as directed.
5. Whether I am taking my medications as prescribed.
6. Whether you have any safety concerns about me (whether to myself or others) and the basis for those concerns.

I give my consent for the purpose of allowing GPP to assist me in my recovery and spiritual growth, to determine my compliance with GPP requirements, rules or practices, and to assess the appropriateness of my entering GPP or continuing to remain a part of GPP. GPP may use and disclose this information only to the extent consistent with this purpose or similar purposes. I do not consent to any use or disclosure of my information for any other purpose.

I do not consent to you releasing any test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS.

I understand that I may withdraw my consent to release the information described above by providing you with written notice. Withdrawal of my consent does not affect any information disclosed before the written notice of the withdrawal is provided to you.

Unless revoked earlier, this consent expires on __________________________.

I have reviewed this Consent and I understand all of its terms.

My Date of Birth: ______________ My Social Security # __________________________

Printed Name: _________________________ Signature: __________________________

Date: _______________________

ADOPTED: NOVEMBER 5, 2016
REVISED 2019