# Jacob's House Recovery Center

## Release of Information

Resident Name:_____

I agree to request from and sign Release of Information forms for all members of my treatment team to release information to employees of Jacob's House Recovery Center. I also authorize Jacob's House to obtain information from these sources. This is meant to facilitate free and open communication.

These include (if applicable):

Treatment Provider

Family Doctor

Vivitrol Doctor

Counselors

Psychologist/Psychiatrist

Family Members

Pastor

All information I hereby authorize to be obtained by Jacob's House will be held strictly confidential and cannot be released without my written consent.

Resident Signature_____Date_____

Staff Signature_____Date_____