July 8, 2015

Dear clients:

It is with much sadness that we inform you that after 20 years, The Sexual Recovery Institute ("SRI") is ceasing operations and closing its doors on July 31, 2015. SRI will be available to provide treatment services through the date of closing.

To ensure you receive care going forward, it is important for you to make arrangements as soon as possible to continue your treatment with a therapist or other provider of services. Should you prefer a discussion with, or personal recommendation from, one of our therapists about continuing treatment, please feel free to speak directly to the therapist of your choice. Otherwise, below is a list of suggested treatment providers in the Los Angeles area.

The Center for Healthy Sex
9911 W. Pico Blvd., Suite 700
Los Angeles, CA 90035
310-843-9902
Centerforhealthysex.com

The Foundry Clinical Group
822 S. Robertson Blvd., Suite 303
Los Angeles, CA 90035
310-721-1894
Foundryclinicalgroup.com

Recovery Help Now
8170 Beverly Blvd.
Los Angeles, CA 90048
310-403-9147
Recoveryhelpnow.com

Once you have selected a continuing treatment provider, you will need to complete an Authorization for Release of Information to allow SRI to forward a copy of your treatment records to your chosen provider. SRI will not able to release your records without proper written authorization from you. For your convenience, enclosed with this letter is an Authorization for Release of Information for you to complete and return to the address listed below upon your selection of a new provider.

Medical Records
11835 W. Olympic Blvd.
Los Angeles, CA 90064

Thank you for having chosen SRI as the provider for your treatment. It has been our pleasure to serve you. We wish you continued recovery and wellness.

Kindest regards,

Monica Blauner, LCSW, CSAT
Program Director

THE SEXUAL RECOVERY INSTITUTE, INC.

Authorization to Use or Disclose Health Information

By completing and signing this document, I authorize use or disclosure of my health information as set forth in this Authorization Form.

____ ________________________________

Client's Name Printed   Date of Birth

____

Telephone Number

Disclosing Individual/Entity

I authorize my health information to be disclosed by:

The Sexual Recovery Institute, Inc.

Recipient Individual/Entity

I authorize my health information to be obtained by:

____
Name
____
Address
____
Telephone

Relationship to Client: __________________________
____

Information to Be Used or Disclosed

Please initial all applicable records to be used or disclosed

Mental Health Records

__ **Complete Mental Health Records**[1]
__ Admission information, including history and physical, psychosocial assessment, laboratory results, diagnosis and prognosis
__ Consultations, psychological results, psychiatric evaluation, neurological work up
__ Progress notes, treatment plan, treatment report attendance
__ Discharge plan and summary
__ Financial and billing information
__ Others ______________________________
____

Alcohol and Drug Records

__ **Complete Alcohol /Drug Records**
__ Admission information, including history and physical, psychosocial assessment, laboratory results, diagnosis and prognosis
__ Consultations, psychological results, psychiatric evaluation, neurological work up
__ Progress notes, treatment plan, treatment report attendance
__ Discharge plan and summary
__ Financial and billing information
__ Aftercare planning
__ Drug/Alcohol Screen Tests
__ Others ______________________________

Other Records (Non-Mental Health, Non-Alcohol and Drug Records)

___ HIV Test Results
___ Other Laboratory Test Results
____ Others ____________________

____Complete medical record
____ Other (Specify) ________________
____

[1] Not including psychotherapy notes per 42 CFR Section 164.508(b)(3)(ii).

Authorization to Use or Disclose Health Information
Client Name: ____________________ Date: ______________ Recipient Individual/Entity: ____

THE SEXUAL RECOVERY INSTITUTE, INC.

Purpose of Use or Disclosure

_______ To facilitate support and involvement in and understanding of treatment
_______ To process insurance claims for services provided
_______ To address payment for services or other financial issues
_______ To develop a diagnosis, treatment and rehabilitation plan
_______ To coordinate treatment and aid in continuing care and treatment
_______ Specify other purpose(s):____

Rights

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time by sending a written notice to the Disclosing Entity listed on page 1 of this form. Revocation of this authorization will not apply to the extent that action has been taken in reliance on my authorization, as permitted by state law.

EXPIRATION: Unless otherwise cancelled, this authorization will expire on:

□ **One Year from signature date** □ **The specified date** ____________

RE-DISCLOSURE: I understand that records disclosed because of this authorization may be re-disclosed and no longer protected by Federal confidentiality regulations (HIPAA). However, I understand that my records may be protected under 42 CFR Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records or state law, which prohibits recipients of these records from re-disclosing this information except with my written authorization or as required by or permitted by such laws.

OTHER RIGHTS: I understand that:

- Authorizing the use or disclosure of my records is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization except as otherwise permitted by law.
- I may inspect or obtain a copy of the information to be used or disclosed.
- I have a right to request a copy of this authorization.
- I have authorized the use or disclosure of my health information as described above for the purposes listed in this authorization form.

Signatures

Client Signature:____ Date:______________

Client Name:____________________________________
Print

Authorized Representative Signature:______________________ Date:______________

Authorized Representative Name:__________________________

Relationship: □Parent □Guardian □Conservator
□Other (Specify)____

Staff/Witness Signature:______________________________ Date:________

Staff/Witness Name:__________________________________
Print