

## Consent for Release of Information

<b>Client Information</b>	Name _____ Date of Birth _____ _____ Address _____ _____ City _____ State _____ Zip Code _____ _____ Phone Number _____
<b>Clinic/Health Care Provider</b> Who has the information to be released?	Name _____ _____ Address _____ _____ City _____ State _____ Zip Code _____ _____ Phone Number _____ Fax Number _____ _____
<b>Receiving Party</b> Who will the information be released to?	Name _____ Relationship to Client _____ _____ Address _____ _____ City _____ State _____ Zip Code _____ _____ Phone Number _____ Fax Number _____ _____
<b>Information to Be Released</b> What will be released?	<input type="checkbox"/> Whether the client is in treatment or not <input type="checkbox"/> Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) <input type="checkbox"/> Nature of the project (Services offered, purpose and philosophy of program) <input type="checkbox"/> Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules) <input type="checkbox"/> Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
<b>Purpose of Release</b> Why is information being	<input type="checkbox"/> Referral to other services <input type="checkbox"/> Coordination of care <input type="checkbox"/> Consultation with Doctor <input type="checkbox"/> Consultation with other mental health provider <input type="checkbox"/> Transfer of care

released?	<input type="checkbox"/> Other _____
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Signature of Client \_\_\_\_\_

Date \_\_\_\_\_

Signature of Provider \_\_\_\_\_

Date \_\_\_\_\_

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: \_\_\_\_\_. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment. FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.