CODA inc.™
health - recovery - community

1-855-SEE-CODA (733-2632)
CALL CENTER HOURS: 8:00AM TO 5:30PM, M-F

ALCOHOL AND DRUG RELEASE OF INFORMATION

I, ______________________________, whose birth date is ______________, do consent to the use or disclosure of the above named individual's treatment information as described below. The following individuals or organizations are authorized to make the disclosure.

SELECT ONE OR MORE: ☐ RELEASE ONLY ☐ RECEIVE ONLY ☐ BOTH

ORG/IND: ______________________ FAX: ______________________

ADDRESS: ______________________ PHONE: ______________________

CITY, STATE, ZIP: ______________________

THE INFORMATION TO BE RECEIVED AND/OR RELEASED IS AS FOLLOWS:

Client to initial items to be released:

______ Assessment/Recommendations
______ Medical Provider Notes
______ Progress in Treatment
______ Presence in Treatment
______ Other (must specifiy) ______________________

______ Most Recent History and Physical
______ Most Recent Discharge Summary
______ Treatment Plan/Progress

______ Current
______ Medication Order
______ US Results
______ Labs
______ Dosing History

PURPOSE OF DISCOLSURE: ______________________

I understand that my treatment record may contain the following information and by initialing, I acknowledge that this information may be released: Acquired Immunodeficiency Syndrome (AIDS) or HIV ________ ; Behavioral Health Services ________ ; Mental Health Services ________ .

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and the Federal Privacy Rule (45 CFR Parts 160 and 164) and cannot be disclosed or re-disclosed without my written consent unless provided for in the regulations. By signing below, I give my consent to the release of my drug and alcohol records to the extent expressly initialed. I also understand that I may, in writing, revoke this consent at any time except to the extent that disclosure was made prior to the time I revoked it. I understand that consenting to the disclosure of treatment information is voluntary. I can refuse to sign this consent and I need not sign this form to ensure treatment.

I understand that, unless I revoke this release, this release will expire on the following date, event, or condition: ______________. The maximum time limit is **1 year** from date signed. **If no date/event is specified above, the consent is invalid.**

Signature of Patient or Legal Representative **Date** **Witness of Signature** **Date**

If Legal Representative, what is your authority to act for the patient? ______________________

I wish to revoke the above Release of Information as of this date:

Date *Time*

Signature of Patient or Legal Representative *Date* *Witness of Signature* *Date*