

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:

Patient to initial items to be released:

- | | | |
|----------------------------------|--|------------------------|
| _____ Assessment/Recommendations | _____ Most Recent History and Physical | _____ Current |
| _____ Medical Provider Notes | _____ Most Recent Discharge Summary | _____ Medication Order |
| _____ Progress in Treatment | _____ Treatment Plan/Progress | _____ UA Results |
| _____ Presence in Treatment | | _____ Labs |
| _____ Other (must specify) _____ | | _____ 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 _____

_____	_____	_____	_____
<i>Signature of Patient or Legal Representative</i>	<i>Date</i>	<i>Witness of Signature</i>	<i>Date</i>

RELEASE OF INFORMATION INSTRUCTIONS

- 1** Always print patient name clearly.
- 2** Always fill in patient birth date.
- 3** Completely fill out the information of the organization and/or individual to whom information will be released.
- 4** The patient must initial what information is to be released.
- 5** Purpose of Disclosure must be noted (some examples: Coordination of Care, Legal Services, etc.).
- 6** If there is any reference to (AIDS) or HIV, Behavioral Health Services, or Mental Health Services in the information that is being released, the patient must initial where indicated.
- 7** The date or event by which the ROI will expire must be filled out. One (1) year is the maximum time limit from the date the ROI is signed.
- 8** The patient must sign with their full legal name.
- 9** If the patient has legal representation, legal court documentation assigning such legal representation must be submitted along with the signed ROI.