
Authorization for Release of Confidential Information

Client Full Name: _____ D.O.B. _____ SSN: _____
Address: _____ City: _____ State: _____
Home Phone: _____ Agency Contact: _____

I DO HEREBY UNDERSTAND AND CONSENT TO **RELEASE / RECEIVE** CONFIDENTIAL LEGAL, MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL AND DRUG/ALCOHOL TREATMENT AND EVALUATION INFORMATION TO THE CUSTODY OF:

[Recovery Support Services Intake Unit], Access To Recovery [Address]
Phone: (808) XXX-XXXX Fax: XXX-XXXX

I understand and consent that the disclosure of this information may be made only as necessary for, and pertinent to, hearings, reports, treatment, coordination of services, and/or supervision concerning authorized Access to Recovery (ATR) service providers.

If I am court ordered to comply with ATR services, I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with drugs and/or alcohol for the above referenced case, such as the discontinuation of all court supervision, my successful completion of the courts or referral agency requirements, or upon sentencing for violating the terms of my court involvement or referring agency contract.

If I am not court ordered to comply with ATR services, I understand that this consent is voluntary and can be revoked by me at any time, either in writing or verbally to the ATR worker at the Recovery Support Services Intake Unit (IU) of ATR. Without specific direction to terminate this Authorization for Release of Confidential Information, it will automatically terminate one year following my discharge from ATR services. Termination of the Authorization for Release of Confidential Information does not apply to information already transferred to other service providers while a valid authorization was in effect. Termination of authorization may not be absolute in the event of a court order to release confidential information. In the event that a court order directs the IU of ATR to disclose confidential information, every effort will be made to respect the client's rights to privacy within statutory regulations.

I fully understand that any disclosure made bound by Part 2 of title 42 of the Code of Federal Regulations, which govern the confidentiality of substance abuse patient and/or client records, and that the recipient of this information may disclose it only in connection with their official duties.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further 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 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.

I understand that coordination of my Recovery Support Services may require that my basic identifying information may be available to other ATR Recovery Support Services Units. This is to avoid duplication of services or record entries. In signing this document, I agree that ATR RSS Units will have access to my basic identifying information. I will not be transferred or referred for primary RSS Unit services without my consent in writing authorizing such a transfer.

The nature of the information to be released is as follows and is subject to the limitations as listed above:

_____ Drug/Alcohol Assessment and Diagnostic Criteria with Levels	_____ Oral and Written Communications
_____ Treatment Recommendations	_____ Consultations
_____ Drug/Alcohol Tests	_____ Background Checks and Searches
_____ May be reviewed by ASI review Committee	_____ History of Abuse
_____ Participation in Recovery Support Services	_____ Attendance and Participation Records

The above information is to be released for the following purposes:

_____ To Aid in Legal Obligations _____ To Aid in Treatment _____ To Aid in Coordination of Services
_____ Other (be specific) _____

In signing this authorization, the undersigned acknowledges that the records disclosed here might be subject to disclosure by/to persons not covered by HIPAA. I do hereby acknowledge that I have read, am familiar with, and fully understand the terms and conditions of this consent.

Signature of Client _____ Date _____
Signature of Legal Guardian _____ Date _____
Witness _____ Date _____