REVOKED ON_____Staff sig._____

CONSENT FOR RELEASE OF INFORMATION CONCERNING SUBSTANCE USE DISORDER CLIENTS

CLIENT'S LAST NAME FIRST M.I.

D.O.B. S.S.N.

FACILITY UNIT

PLEASE GIVE A COPY OF THE FORM TO THE CLIENT. Please place a copy in the client's case record.

## DISCLOSURE/RELEASE WITH CLIENT'S CONSENT

INFORMATION TO BE RELEASED: Psychosocial/psychiatric/psychological/medical/vocational evaluations, lab results, level of care determination, progress in treatment, reasons for referral

PURPOSE OR NEED FOR DISCLOSURE/RELEASE: To facilitate access to substance use disorder services and to enhance continuity of care

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION

Between:_____

DISCLOSURE/RELEASE IS TO BE MADE TO

And: Rapid Engagement Demonstration Care Facilitator

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire twelve (12) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of substance use disorder client records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information outside of the Monroe County CD and MH SPOA participants is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:_____

_____

Any information released through this form will be accompanied by the form Prohibition on Redisclosure of Information Concerning Substance Use Disorder Clients (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Client)

_____ (Signature of Parent/Guardian, when required)

_____ (Print Name of Client)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)

(First print 01/25/07)