Consent to Release Confidential Information

I, _____, of _____
Name of client City State

by my signature below, consent for the release of confidential information specified below and authorize Educational Service District #113 True North Treatment Services to exchange information to the following person(s) or agency:

_____
(name of person/organization to which disclosure is to be made)

Type of Information to be Released:

(Client must initial all applicable items; non-applicable items should be marked "N/A")

Initials

_____ Behavioral health assessment, evaluation, diagnosis, treatment recommendations, and prognosis

_____ Treatment history and general progress report information

_____ Legal, social, education, and vocational history

_____ Medical and medication information, including diagnosis and prognosis of client

_____ Results of urinalysis and other drug or alcohol monitoring tests

_____ Emergency contacts

_____ Identifying information, including name, birth date, SSN, dates admitted to and discharged from program

_____ Discharge Summary and recommendations

_____ True North Program attendance

_____ Other _____

Purpose of Information:

(Client must initial all applicable items; non-applicable items should be marked "N/A")

Initials

_____ Assist in appropriate treatment placements

_____ Exchange and verify client case planning information

_____ Access in emergency situations

_____ Verification of abstinence

_____ Other _____

This consent will be in effect until ninety (90) days after discharge from True North treatment. This consent is subject to revocation at any time except to the extent the program has already taken action in reliance on it.

NOTICE: This information is disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making 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 my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g., Tuberculosis, HIV/AIDS-AID related illness), mental health services governed by RCW 71, drug and/or alcohol services governed by 42 CFR Part 2. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized re-disclosure by recipient is a potential risk. I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment or payment. In any event this authorization expires automatically as follows: 90 days from date of discharge from True North treatment.

_____ _____
Client Signature Date Program Representative Date

_____ _____
Parent/Guardian Signature Date Witness Date