CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, ____________________________________

(name of the patient or participant)

authorize

the exchange of information between

EVERGREEN TREATMENT SERVICES

and

__________________

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

the following information:

☐ Medical Reports

☐ Lab Reports

☐ Attendance at Agency Appointments

☐ Psychiatric Assessment & Treatment

☐ Treatment Modality and Plan

☐ STD information

☐ Other: ______________________

The purpose or need for such disclosure is to (be as specific as possible):

________________________________________________________________________________.

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 Accounting Act (45 CFR §160 & 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Further disclosure is prohibited unless expressly permitted by my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

________________________________________

(Specification of the date, event, or condition upon which this consent expires)

In any event this consent expires automatically, as specified above, in 90 days without such specification.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been offered a copy of this form. ☐ Offered & Declined ☐ Copy Given

Signature of Patient __________________________

Initials __________________________

Date ____________

Witness __________________________