CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____authorize the exchange of information between
(name of the patient or participant)

EVERGREEN TREATMENT SERVICES and _____
(name of person or organization to which disclosure is to be made)

the following information:

_____☐ Urine/BAL Test Results
_____☐ Drug and Alcohol History
_____☐ Counselor's Assessment of treatment progress
_____☐ Group Participation
_____☐ HIV/AIDS information
_____☐ Social Security No. and Date of Birth
_____☐ 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):_____

_____.

Dates of Service Requested: _____

Address to send records:_____

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