ALCOHOL & DRUG DEPENDENCY SERVICES OF SOUTHEAST IOWA

_____authorize release of the following information:
(your name)

_____ Name and admission status,
_____ Intake and initial evaluation,
_____ Social History,
_____ Comprehensive Treatment Plan,
_____ General progress including compliance with treatment plan,
_____ Discharge Summary,
_____ Evaluation and Recommendations,
_____ Urinalysis results,
_____ Dates and time of appointments,
_____ Other _____

FROM _____
(organization or individual releasing information)

TO _____
(organization or individual to whom information is being released)

I understand that this information will be used:
_____ To provide further information for evaluation/assessment,
_____ To assist in developing a treatment plan,
_____ To coordinate client services,
_____ To inform referral source that individual kept appointments,
_____ To schedule or to reschedule appointments,
_____ To acknowledge presence in facility,
_____ To assist in the collection of treatment fees,
_____ To _____

I understand that my alcohol and/or drug treatment and/or problem gambling records are protected under the state and federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records. This includes 42 C.F.R. Part 2 (for substance abuse only) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. 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 (complete one item below):

_____ at the end of _____ days,
_____ by the following event or condition _____

Signature _____D.O.B._____

Parent/Legal Guardian (when applicable) _____

Date _____

Revised 1/15/2008