AMERICAN
BEHAVIORAL HEALTH SYSTEMS

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ DOB: _____ hereby authorize an exchange of both verbal and written information between the Chemical Dependency Programs at American Behavioral Health Systems and
Agency: _____
Address: _____
Phone: _____ FAX: _____ Email: _____

The information to be released and exchanged is: ***(Client must initial next to each item they are requesting)***

☐ **Identifying Information**
☐ CD Assessment Summary/Recommendations
☐ Psychosocial History
☐ Mental Health Assessment
☐ Diagnostic Summary
☐ Problem List
☐ Treatment Plans
☐ Continuing Care Plan
☐ **CD Counselor Discharge Summary**
☐ Treatment Summary

☐ **Treatment Progress Reports**
☐ Treatment Participation/Compliance
☐ Deferred Prosecution Reports
☐ Physical H & P/Discharge Summary
☐ Lab Tests, including urine drug screen/BAL,
☐ Tuberculosis (TB skin testing results/Tx)
☐ Education Records including testing results
☐ Consultation
☐ Other (Specify): _____

The purpose or need for the exchange and disclosure of this information is to:

☐ Authorize Facilitate Treatment
☐ Summarize Treatment
☐ Facilitate Billing
☐ Facilitate School Credit
☐ **Coordinate Continuing Care**
☐ Other (specify):

Delivery instructions: ☐ Mail ☐ FAX ☐ Email ☐ Phone

I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2 and 45 CFR Parts 160 & 164 and cannot be further disclosed without my written consent unless otherwise provided for in the regulations. I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create any assessment or report for disclosure to the recipient identified in this authorization. Generally, American Behavioral Health Systems 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 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, and that in any event this consent will expire 60 days following discharge from the treatment program or _____

By signing this form, I acknowledge that I understand and agree to these terms and received a copy of this form.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Witness Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Part 2). The Federal rules prohibit you from making any 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 and HIPAA, 45 CFR Parts 160 & 164. 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 Client.