

THE GATEHOUSE

RESTORING THE HUMAN SPIRIT THROUGH RECOVERY

Consent for the Release of Confidential Information

I, _____, authorize The GateHouse to disclose to
(name of client)

_____ the following information (please check
(name of individual and organization)

all that apply):

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> <i>Presence in Treatment</i> | <input type="checkbox"/> <i>History & Physical</i> | <input type="checkbox"/> <i>Urinalysis</i> |
| <input checked="" type="checkbox"/> <i>Demographic Information</i> | <input type="checkbox"/> <i>Discharge Summary</i> | <input type="checkbox"/> <i>Biopsychosocial</i> |
| <input checked="" type="checkbox"/> <i>Medications Prescribed</i> | <input type="checkbox"/> <i>Aftercare</i> | <input checked="" type="checkbox"/> <i>Follow Up</i> |
| <input checked="" type="checkbox"/> <i>Nature of Project</i> | <input checked="" type="checkbox"/> <i>Prognosis</i> | |
| <input checked="" type="checkbox"/> <i>Brief Description of Progress</i> | <input type="checkbox"/> <i>Nature of Emergency</i> | |
| <input checked="" type="checkbox"/> <i>Whether the client has relapsed into active use</i> | | |

The purpose of the disclosure is to authorize communication pertaining to (check all that apply):

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> <i>Chemical Dependency Treatment</i> | <input type="checkbox"/> <i>Physical/Mental Health</i> | <input type="checkbox"/> <i>Family/Friend/Partner</i> |
| <input type="checkbox"/> <i>Legal Counsel</i> | <input type="checkbox"/> <i>Employer</i> | |
| <input type="checkbox"/> <i>Criminal Justice System Reporting Requirements</i> | | |
| <input type="checkbox"/> <i>Obtaining the Following Benefits:</i> _____ | | |
| <input type="checkbox"/> <i>Other:</i> _____ | | |

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Client Records, 42 C.F.R. Part 2, 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 by the regulations. I understand that in general my treatment may not be conditioned upon 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 or verbally 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:

Ex. Date

Client Signature

Date

Client Signature

Date

Client *has accepted* *has **not** accepted* a copy of this form.