AUTHORIZATION AND CONSENT TO RELEASE
ALCOHOL AND DRUG TREATMENT RECORD

PLEASE PRINT

I, _____, authorize WellSpace Health to exchange information to and/or from the following:

Name: _____

Agency Name: _____

Address: _____

Telephone Number: _____

Specific information to be released and/or requested: _____

_____

This information is authorized to be released and/or requested to/from the above named party for the sole purpose of: _____

Emergency Contact _____

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR part 2, and 45 CFR (HIPAA). Authorization, 42 CFR states that client records 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 on the date specified below. Under HIPAA 45 CFR, I understand that an agency / program may not condition treatment, payment and/or enrollment in a health plan or eligibility for the benefits on signing of this authorization by client.

The potential for information disclosed pursuant to the authorization will be subject to re-disclosure by the recipient and no longer protected by the privacy rule. In other words, after we give information about you to another organization (such as a government agency or a hospital), we no longer have control over who sees that information.

_____

If I do not otherwise direct, this consent will expire twelve months after the date below.

_____ _____
Client Signature **Date**

_____ _____
Staff Signature **Date**