

INFORMED CONSENT TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

I, \_\_\_\_\_, CLIENT'S NAME SOCIAL SECURITY NUMBER \_\_\_\_\_

authorize INSIGHT HOUSE CHEMICAL DEPENDENCY SERVICES, INC. 500 WHITESBORO STREET, UTICA, NEW YORK 13502 (315) 724-5168

( ) to release to ( ) to obtain from For two-way communication, check both boxes and all appropriate boxes below

NAME, TITLE AND/OR ORGANIZATION TO WHOM INFORMATION IS TO BE RELEASED/OBTAINED

ADDRESS/CITY/STATE/ZIP/TELEPHONE NUMBER

the following information:

- ( ) INSURANCE, EMPLOYMENT, P.A., S.S. BENEFITS ( ) SOCIAL SERVICE RECORDS/PLANS
( ) PRESENCE IN TREATMENT ( ) FAMILY HISTORY
( ) MEDICAL HISTORY AND PHYSICAL ( ) EDUCATION/VOCATIONAL RECORDS
( ) DIAGNOSIS AND PROGNOSIS ( ) PROGRESS NOTES
( ) DISCHARGE SUMMARY ( ) TREATMENT PLANS
( ) PROGRESS IN TREATMENT/COMPLIANCE WITH TREATMENT RULES/RECOMMENDATIONS ( ) PSYCHOLOGICAL AND/OR PSYCHIATRIC TESTS AND/OR ASSESSMENTS
( ) LABORATORY DATA ( ) PROBATION/PAROLE/COURT RECORDS AND/OR REPORTS
( ) PSYCHOSOCIAL HISTORY/ASSESSMENTS/TREATMENT RECOMMENDATIONS
( ) UNRESTRICTED COMMUNICATION WITH PAROLE/PROBATION/OTHER SPECIFY:
( ) OTHER SPECIFY:

for the following purpose(s):

- ( ) TO PROVIDE ONGOING TREATMENT ( ) TO PROVIDE EDUCATIONAL SERVICES
( ) TO COORDINATE TREATMENT AND CONTINUING CARE ( ) TO DEVELOP A PLAN OF TREATMENT
( ) TO OBTAIN INSURANCE, EMPLOYMENT, OR GOVERNMENT BENEFITS ( ) TO COORDINATE TREATMENT EFFORTS WITH FAMILY OR CONCERNED PERSONS
( ) TO COMPLETE A FULL ASSESSMENT ( ) TO DETERMINE ELIGIBILITY
( ) TO ENABLE JUDGES, ATTORNEYS, PROBATION, PAROLE OFFICERS TO SUPPORT TREATMENT GOALS OR MAKE LEGAL DECISIONS ON MY BEHALF
( ) TO MONITOR CONDITIONS OF PAROLE/PROBATION/OTHER COURT ORDERED REQUIREMENTS
( ) TO REDISCLOSE TO FEDERAL AND/OR STATE AGENCIES RESPONSIBLE FOR APPROVING CHANGES IN CLAIMING CATEGORIES OR DISABILITIES DETERMINATIONS
( ) OTHER(SPECIFY):

I, the undersigned, understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42C.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 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. This consent shall expire twelve (12) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. Redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

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 advised that I can receive a copy of this consent form.

[ ] I do not want a copy of this consent form
[ ] I want a copy of this consent and have been provided with one. DATE: \_\_\_\_\_

Signature of Patient Signature of person signing form if not patient

SIGNATURE OF PARENT/GUARDIAN, WHERE REQUIRED

Describe authority to sign on behalf of patient \_\_\_\_\_

A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL FORM