REVOKED ON_____ Staff Sig._____

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

( ) PRESENCE IN TREATMENT

( ) MEDICAL HISTORY AND PHYSICAL

( ) DIAGNOSIS AND PROGNOSIS

( ) DISCHARGE SUMMARY

( ) PROGRESS IN TREATMENT/COMPLIANCE WITH TREATMENT RULES/RECOMMENDATIONS

( ) LABORATORY DATA

( ) PSYCHOSOCIAL HISTORY/ASSESSMENTS/TREATMENT RECOMMENDATIONS

( ) UNRESTRICTED COMMUNICATION WITH PAROLE/PROBATION/OTHER SPECIFY:_____

( ) OTHER SPECIFY):_____

( )SOCIAL SERVICE RECORDS/PLANS

( )FAMILY HISTORY

( )EDUCATION/VOCATIONAL RECORDS

( )PROGRESS NOTES

( )TREATMENT PLANS

( )PSYCHOLOGICAL AND/OR PSYCHIATRIC TESTS AND/OR ASSESSMENTS

( )PROBATION/PAROLE/COURT RECORDS AND/OR REPORTS

for the following purpose(s):

( ) TO PROVIDE ONGOING TREATMENT

( ) TO COORDINATE TREATMENT AND CONTINUING CARE

( ) TO OBTAIN INSURANCE, EMPLOYMENT, OR GOVERNMENT BENEFITS

( ) TO COMPLETE A FULL ASSESSMENT

( ) 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

( ) TO PROVIDE EDUCATIONAL SERVICES

( ) TO DEVELOP A PLAN OF TREATMENT

( ) TO COORDINATE TREATMENT EFFORTS WITH FAMILY OR CONCERNED PERSONS

( ) TO DETERMINE ELIGIBILITY

( )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

REVISED 05/24/05