COMPASS Health

Chemical Dependency Program

Authorization to Release Alcohol/Drug Abuse Records and Information

(*Complete or affix label*) ***Client Name:*** _____	Previous/Maiden Name or Alias	
Client ID: _____	DOB:	Social Security No:

COMPASS HEALTH

Address: _____

_____

Phone: _____

Fax: _____

Attn: _____

Compass Health may ☐ Disclose ☐ Receive ☐ Exchange the protected health information indicated below with

Person or Facility: _____

Address: _____

_____

Phone: _____

Fax: _____

Extent and Nature of Disclosure:	**Purpose of this Disclosure:**
❑ Alcohol/Drug use history, diagnostic impression, symptomology ❑ Biographical, family, psychological and social history ❑ Evaluation results and recommendations ❑ Previous treatment history and success/compliance ❑ Abstinence status, attendance records ❑ Progress reports and diagnosis ❑ Discharge summary, aftercare plans, prognosis ❑ Results of urinalysis, breathalyzer and/or lab tests ❑ Cooperation with treatment program ❑ DCFS and CPS file records ❑ Re-disclosure of inpatient chemical dependency treatment records ❑ Other _____	The disclosure of the above information and records is for the specific purpose of supporting the patient in ongoing clinical care, transfer, or informing involved referral sources of treatment activity. Additional purposes of this release include: _____ (write "none" if no additional purposes of this release)

I understand that my record may contain information regarding diagnosis or treatment of mental health issues. I give my specific authorization for these records to be disclosed. (per RCW 71.05.390)	(initials)
I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	(initials)

Information may be transmitted by any secure means listed below unless limited by patient instructions.

☐ Letter ☐ Phone ☐ Fax/Electronic

Instructions for limiting transmission of information: _____

(write "none" if there are no limitations to methods of transmission)

I understand that my records are protected under the Federal (42 CFR Part 2) and State Confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. 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 (e.g. probation, parole, etc.) and that, in any event, this consent expires on the expiration date or event noted below. I understand that information used or disclosed in keeping with this authorization may no longer be protected by Federal Law and could be used or re-disclosed by the receiving party. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain enrollment, treatment (or payment, if applicable) from Compass Health.

I understand that this release will automatically expire upon my discharge from chemical dependency services at Compass Health, unless an event or date of expiration is specified below:

☒ A formal and effective termination or revocation of my release from confinement, probation, parole, or other proceeding under which I was mandated into treatment.

OR

☐ _____

_____

specify a date or event when consent expires (must be explicit)

_____ _____

Signature of client, or client's parent/guardian/legal representative Date