central peninsula behavioral health

serenity house | diamond willow | outpatient services

Intake Office (907) 714-4521 Fax (907) 260-4063
245 N. Binkley St. Suite 202
Soldotna, AK 99669

Consent for Release of Confidential Information

Client Name:_________________________ _**Date of Birth:**___/___/_____
Guardian Name (if child under the age of 18):______________________**Date of Birth:**___/___/_____
authorize the mutual exchange of information and communication between Central Peninsula Behavioral Health & ____.
Phone # _______________________ fax # _____________________ and I authorize the information to be exchanged verbally, in writing, and/or by fax.

I am aware that disclosure information may include alcohol/drug abuse information, and/or psychological/ psychiatric information. I authorize the following information to be exchanged:

(**Please <u>initial</u> which information will be released**)

_____ Acknowledge presence in treatment/attendance
_____ History pertinent to this referral
_____ Diagnosis
_____ Urinalysis results
_____ Treatment plan
_____ Treatment records
_____ Discharge Summary, status
_____Treatment recommendations
_____ Substance abuse assessment
_____ Program compliance
_____ Prognosis
_____ Psychological/Psychiatric assessment
_____ Psychological/Psychiatric reports
_____ Medical records
_____ Other_____________________________________

The above information is to be exchanged for the purpose of:_____________________________________

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 cannot be disclosed without my written or verbal 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 previous to written revocation of this document and that in any event this consent expires: **(Specify event, date[s], or condition)**
If left blank, this specific authorization will expire 6 months from the date of my signature

____

Signature of Client _____________________________________ Date: ___________________

Signature of Witness_____________________________________ Date: ___________________

Signature of Parent/Guardian _____________________________ Date: ___________________

Records from which this information has been disclosed are confidential and protected by Federal Confidentiality Rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom the information pertains or as permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for release of alcohol and drug abuse client records. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (Revised June 2012)

Place ID
Sticker Here