



CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION (rev. 3-08)

NAME: _____ D.O.B: _____ S.S.N: _____

I, _____ authorize
(Name of client)

_____ to disclose to _____ the following information:
(Name or general designation of program making disclosure)
(Name of person or organization to which disclosure is to be made)

(Nature and amount of information to be disclosed, as limited as possible. All items must be completed. Check "NA" if not applicable.)

- Psycho/social history Yes NA
- Medications Yes NA
- Treatment summary Yes NA
- Treatment recommendations Yes NA
- Discharge summary Yes NA
- Reason for referral Yes NA

Under Pa. Code, information released to judges, probation or parole officers, insurance company, health or hospital plan or government officials for determining continuing stay is restricted to:

- Whether client is/is not in treatment Yes NA
- Client's Prognosis Yes NA
- Nature of the treatment program Yes NA
- Brief description of client's progress Yes NA
- If client has relapsed/relapse frequency Yes NA

The purpose of the disclosure authorized in this is to _____
(purpose of disclosure, as specific as possible):

I understand that I am hereby giving my consent for the release of treatment information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Client Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing or verbally at any time. I also understand that if I choose to revoke my consent, it can only be revoked to the extent that Sojourner House has not acted in reliance upon the consent or if this consent was signed as a condition of obtaining insurance coverage. In any event this consent expires automatically one calendar year from today's date or as follows.

(Specification of the date, event or condition upon which this consent expires)

I understand that Sojourner House may not require that I sign this consent form in order to obtain treatment.

Client signature: _____ Date _____

Signature of authorized representative where required _____

(If legal representative indicate basis for authority (e.g. parent of minor; power of attorney; guardian, other.) _____

Witness signature _____ Date: _____

I accept () or reject () a completed and signed copy of this form. *(Client must initial 'accept' or 'reject')*

NOTE: A faxed copy may be considered a valid record.