OneEighty

CONSENT FOR THE RELEASE OF INFORMATION

Client Name:_____ Date of Birth: _____

I, _____, hereby consent to communication from and between OneEighty, Inc.

And _____ (_____) _____ - _____ (_____) _____ - _____

(Name of entity to whom information is to be released) (phone) (fax)

Purpose and need for disclosure: Order of the Court_____

Information to be released:

____ Attendance	____ Treatment History	____ Housing Coordination Plan
____ Treatment Plan	____ Treatment Recommendations	____ Housing Status
____ Diagnosis	____ Progress Notes	__**X**__ Other AEP Report_____
____ Diagnostic Assessment	____ Participation	_____

Amount of information to be disclosed:

____ Information covering the most recent admission

____ All treatment

_**X**__ Other: Information from most recent AEP Program_____

I understand that this consent will remain in effect until:

__**X**__ 180 days from my signature

_____ _____

(Specify other time period or condition/event when consent can be revoked or expires)

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as other authorized by law; however, I understand that OneEighty, Inc. cannot control the above entity's use of the information. I understand that my treatment, payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information FOR ANY OTHER PURPOSE.

_____ _____

Signature of Client **Date**

_____ _____

If appropriate, signature of Parent/Guardian/Personal Representative (with description of relationship and authority to act on behalf of client. Required for all minors) **Date**

_____ _____

Signature of Staff **Date**

REVOCATION: This authorization is subject to revocation at any time except to the extent the program or person who is making the disclosure has already acted in reliance upon it. The consent can be revoked either verbally or in writing.

I hereby revoke consent ____ in writing ____ verbally Time if verbally revoked: _____ Date:_____

Signature of client/parent/guardian or staff witness to verbal revocation:_____

Client given copy _____ (Client initials) **Client declined copy** _____ (client initials)

Prohibition against re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 F.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol/drug abuse or mentally ill client.