

OneEighty

CONSENT FOR THE RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

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

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

Purpose and need for disclosure: _____

Information to be released:

<input type="checkbox"/> Attendance	<input type="checkbox"/> Treatment History	<input type="checkbox"/> Housing Coordination Plan
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Treatment Recommendations	<input type="checkbox"/> Housing Status
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Urine Drug Screen/ Urinalysis Results
<input type="checkbox"/> Diagnostic Assessment	<input type="checkbox"/> Participation	
<input type="checkbox"/> Other _____		

Amount of information to be disclosed:

Information covering the most recent admission
 All Substance Use Treatment Information/Records
 All Mental Health Treatment Information/Records
 Other: _____

I understand that this consent will remain in effect until:

_____ 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 otherwise 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

REVOCACTION: 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 C.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.