✔ Marked sections MUST be completed to be valid

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:**

_____Attendance	_____Treatment History	_____Housing Coordination Plan
_____Treatment Plan	_____Treatment Recommendations	_____Housing Status
_____Diagnosis	_____Progress Notes	_____Urine Drug Screen/
_____Diagnostic Assessment	_____Participation	Urinalysis Results

_____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**

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:_____

*Choose one *__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.