ADULT PACKET

INTAKE PACKET

Congratulations
On Your Decision To Make A Change Toward Recovery!

Read This Page Thoroughly Before Moving To The Next Page

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS PACKET

- ☐ Fill out this packet ***COMPLETELY*** **PRIOR** to your assessment and/or intake being scheduled.
- ☐ Provide a copy of your valid photo ID and a copy of your insurance card. Thank you.
- ☐ Answer ALL Question
- ☐ Write N/A On Questions That Do Not Pertain To You
- ☐ Leave No Questions Unanswered
- ☐ Write In Black Or Blue Ink Only – NO PENCIL
- ☐ **Complete A Release Of Information (ROI)**
  - **Must Be Completed For Each Agency Referring You**
  - **Example List & Example ROI Are In The Intake Packet – PLEASE REVIEW**
- ☐ **INCOMPLETE PACKET WILL NOT BE PROCESSED UNTIL FULLY COMPLETED BY THE CLIENT**
  - **Help CIC Help You By Providing A *COMPLETED* Packet.**
- ☐ **IT IS THE RESPONSIBILITY OF THE CLIENT(YOU) TO FOLLOW-UP WITH CIC TO SCHEDULE AN APPOINTMENT**
- ☐ **INTAKE PACKET EXPIRES AFTER 30 DAYS OF NO CONTACT FROM CLIENT**

Questions:

Please Contact Annette, Case Manager
Mon. – Fri. 8:00am to 4:00pm @ 907.283.3658

➢ Once packet is FULLY COMPLETED, you can drop off, mail or email to either of the addresses below:

- For Kenai: 10200 Kenai Spur Hwy, Kenai, AK 99611
- For Homer: 1230 Ocean Drive, Unit 1, Homer AK 99603
- E-Mail: *officeadministrator@alaskacicada.org*

OFFICE USE ONLY	DATE RECEIVED:	DELPHI:	CLIENT ID:	COUNSELOR:	APPT DATE: TIME:

10200 Kenai Spur Hwy, Kenai, AK 99611 ♦ Kenai Phone 283-3658
1230 Ocean Drive, Unit 1, Homer, AK 99603 ♦ Homer Phone 235-8001

INTAKE PACKET

CLIENT INFORMATION

Name: _____ Other Names Used: _____
Last **First** **M.I.**

Address: _____
Street Address **City** **State** **Zip**

Mailing: _____

Cell Phone: _____ Home Phone: _____ Ok To Leave Detailed Message ☐ Yes ☐ No

DOB: _____ Age: _____ Gender: _____ Sexual Preference: _____

Race: _____ SSN: _____ Place of Birth: _____

Referring Agency: (***What Agency(s) Referred You***)? _____
Examples: ASAP, Probation, PED, OCS

Prior Military Service? ☐ Yes ☐ No If so, what branch & how long: _____

METHOD OF PAYMENT

PLEASE NOTE: Medicaid covers specific treatment services. The cost of non-covered services is the Client's responsibility. If you have Medicaid and other insurance coverage, please complete the information requested below.

COPY OF INSURANCE CARD(S) MUST BE PROVIDED

☐ **Self-Pay** Client's Initials: _____ ☐ **Medicaid** ID # _____

☐ **Private Insurance**
Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Number: _____ Group # _____ SSN: _____

Name of Insurance Company: _____

☐ **Secondary Insurance**
Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Number: _____ Group # _____ SSN: _____

Name of Insurance Company: _____

MEDICAL HISTORY

Are you currently taking any of the medications listed below? ☐ Yes ☐ No

☐ Buprenorphine ☐ Suboxone ☐ Subutex ☐ Sublocade ☐ Naltrexone ☐ Vivitrol ☐ Other

If yes, are you currently taking as prescribe by your physician? ☐ Yes ☐ No

Who is your prescribing physician? _____

When was your last dose taken? _____

Release of Information signed for this prescribing agency? ☐ Yes ☐ No

How do you rate your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you have any medical conditions? ☐ Yes ☐ No Are you allergic to any medication or drugs? ☐ Yes ☐ No

If yes to any of the above, please list them: _____

_____

List of medications you're currently taking: _____

_____

_____

Any history of serious illnesses or surgeries? ☐ Yes ☐ No

If so, please list them: _____

Any history of head injuries? ☐ Yes ☐ No If yes, describe (fighting, falling, car accident, been unconscious, etc):

_____

_____

Did you receive medical attention? ☐ Yes ☐ No

Do you have any medical condition that may interfere with treatment? ☐ Yes ☐ No

Please describe: _____

_____

Have you ever blacked out or passed out while drinking? ☐ Yes ☐ No

Have you experienced withdrawl symptoms after drinking or using? ☐ Yes ☐ No

If yes, what symptoms were present: ☐ Hallucinations ☐ Sweating ☐ Seizures

☐ Tremors ☐ Nausea/Vomitting ☐ Achy Joints ☐ Depression ☐ Unable to Sleep

Have you had prior substance abuse treatment? ☐ Yes ☐ No

Where, When and How Long? _____

Was treatment completed successfully? ☐ Yes ☐ No

Release of Information signed for this/these agencies? ☐ Yes ☐ No

Please thoroughly ***Complete*** Substance Use History:

- Check ***N/A*** if that substance was never used.

This section is based off your past and present.

SUBSTANCE USE HISTORY

Substance	N/A	Age First Used	Age It Became A Problem	Amount Used In The Last 6 Months	Method Of Use	Date Last Used
Alcohol						
Cannabis						
Cocaine						
Amphetamine Methamphetamine						
Hallucinogens						
Designer Drugs						
Opiates/Heroin						
Suboxone Methadone						
Benzodiazepines						
Sedative/Hypnotics						
Synthetic Drugs						
Other drugs:						

LEGAL

Are you currently involved in the legal system? ☐ Yes ☐ No

Date of Arrest	Charge	Conviction or Pending

Do you need your assessment released to any organization or entity? ☐ Yes ☐ No

Release of information signed specifically for that organization or entity? ☐ Yes ☐ No

Are you currently involved with Adult Probation or Pretrial Enforcement Division? ☐ Yes ☐ No

Release of information signed specifically for that organization? ☐ Yes ☐ No

EMOTIONAL/BEHAVIORAL

Are you currently involved in AA or NA? ☐ Yes ☐ No If yes, do you have a sponsor? ☐ Yes ☐ No

Outside of legal or treatment entities, where do you get your support? _____

Have you ever received mental health treatment? ☐ Yes ☐ No

If yes, Where: _____ When: _____

Current mental health diagnosis? ☐ Yes ☐ No If yes, provide diagnosis _____

Have you ever experienced suicidal thoughts? ☐ Yes ☐ No If yes, When: _____

Do you have any history of suicide attempts? ☐ Yes ☐ No

Have you ever experienced homicidal thoughts? ☐ Yes ☐ No If yes, When: _____

Personal strengths in life: _____

Personal current needs: _____

Abilities (Attributes about you, you are proud of): _____

Treatment preferences: _____

FAMILY HISTORY

Have you experienced a deeply distressing or disturbing experience? Please describe.

_____

_____

_____

_____

Briefly describe your childhood history. Who raised you (siblings, stepparents, etc.)? Drugs and alcohol in the home? History of abuse (physical, mental, verbal, emotional and sexual)?

_____

_____

_____

_____

_____

Current family relationships:

_____

_____

Current living situation:	☐ Rental	☐ Own Home	☐ Shelter	☐ Transitional Housing
	☐ Family	☐ On the Street	☐ Group Home	☐ Other _____
Current living arrangement:	☐ Alone	☐ Temporary	☐ Permanent	☐ Relations/Friends
Current relationship status:	☐ Married	☐ Engaged	☐ Single	☐ In A Relationship
	☐ Divorced	☐ Separated	☐ Widowed	☐ Other _____

Do you have children? If so, please list them including their age and gender.

_____ _____ _____

_____ _____ _____

OFFICE OF CHILDREN SERVICES & TRIBAL COURT

Do you have an open Office of Children Services case? ☐ Yes ☐ No

If yes, please list the Reason, Case Workers Name and Contact Information. _____

_____

_____

_____

Release of Information Signed for OCS? ☐ Yes ☐ No

Do you have an open **Tribal Court** case? ☐ Yes ☐ No

If yes, please list the Reason, Case Workers Name and Contact Information. _____

_____

_____

_____

Release of Information Signed for Tribal Court? ☐ Yes ☐ No

EDUCATIONAL HISTORY

Are you currently enrolled in school, college, or a job training program?

☐ Not enrolled ☐ Enrolled, Full Time ☐ Enrolled, Part Time ☐ Other (Specify)

Highest level of education you have completed? _____

If less than 12 years of education, do you have a GED? ☐ Yes ☐ No

EMPLOYMENT HISTORY

Are you currently employed? ☐ Yes ☐ No ☐ Part Time ☐ Full Time

Who is your current employer? Please provide name and phone number below

_____

How long have you been employed? _____

Have you ever missed work, been disciplined, or terminated due to alcohol or drugs? ☐ Yes ☐ No

If so, when? _____

Describe what happened _____

_____

_____

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

FINANCIAL CONTRACT

The cost for treatment at CIC is as follows:

• Substance Abuse Assessment	(Includes AST, Initial CSR & Assessment UA)	$311.61
• Integrated Assessment	(Includes AST, Initial CSR & Assessment UA)	$576.88
• Quarterly CSR		$42.15

• Individual Counseling	$103.00	• Case Management	$112.28 per hr.
• Group Counseling	$57.68 per hr.	• Breath Test	$25.00
• ADIS Only	$200.00	• UA	$45.00

Your total annual household income is: $_____

- **Monthly Service Payment Required:** Payments are strongly encouraged as services are provided.
- **Your monthly payment of $_____ begins 30 days from date of appointment.**
  - **Provide Amount You're Eligible To Pay** ➢ **No Less Than $25.00**
  - **Payment Amount Required For ALL Clients, Insured & Uninsured.**

If you have a financial hardship, please ask for a sliding fee scale form.

For clients entering treatment, CIC offers a sliding fee payment agreement for those who need assistance financially. In order to be approved, you will need to bring in the financial information listed on the attached Eligibility Determination Worksheet within 10 days. If you do not bring the required information, you will be billed at the full fee. You will be notified what level you qualify for on the sliding fee scale by the finance department.

If you miss two of your monthly payments or your account goes to collections (90 days past due) this is cause for discharge as non-compliant. Anytime your financial situation changes, your contract can be re-negotiated at your request.

THIRD PARTY BILLING

If a third-party billing source is intended as a payment method, the following is required:

1. CIC is authorized to release any information required to process insurance or other third-party claims.
2. Payments from third party payers need to be paid directly to CIC.
3. You are responsible for paying any non-covered services and/or partially covered charges.
4. You are responsible for providing all information necessary to file a claim. Failure to do so will result in you being fully responsible for the cost of services.
5. Even with insurance, etc. you are responsible for keeping your account current. A payment is due on your account every month even if you expect insurance to cover the cost but has not paid.

COLLECTION

If your account becomes 90 days past due, CIC is authorized to turn your account over to a collection agency. Federal law regulating confidentiality (CFR 45 and HIPAA) allow CIC to disclose such billing information as is necessary to collect fees without written consent from you when an active business associate's agreement between the agency and CIC exists.

Client Name (Please Print):_____ Date: _____

Date of Birth: _____ Social Security Number:_____

Client Signature:_____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Staff Signature:_____ Date: _____

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611PHONE
PHONE (907)283-3658 ♦ FAX (907)283-5046

THIRD PARTY BILLING CONSENT TO RELEASE CONFIDENTIAL INFORMAION

I (client name) _____ authorize Cook Inlet Counseling to mutually disclose and re-disclose the following information using verbal, written, electronic, and faxed communication:

Identification, diagnosis, services received, and other information required for billing and travel arrangements with:

Medicaid: _____ Private Insurance: _____

(INITIAL ALL THAT APPLY TO YOU)

Name of Insurance Provider: _____

Name of Policy Holder: _____ SSN: _____

Date of Birth of Policy Holder: _____ Phone Number: _____

Insured Policy Number: _____ Group # _____

This release covers both the insurance company and the policy holder.

The purpose of this release is to: *Exchange Information Necessary for Billing Purposes*

In addition, I hereby authorize: *My benefits to be paid directly to CIC*
I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

When all fees have been collected and or the account is closed
(specification of the date, event, or condition upon which this consent expires)

I understand that generally CIC may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____ _____
Signature of Client Date of Birth Date signed

_____ _____
Signature of Witness Signature of Parent or Legal Guardian

PROHIBITION TO REDISCLOSE CONFIDENTIAL INFORMATION

This information disclosed to you concerns a client in alcohol/drug treatment and is made to you with the consent of such client. This information has been disclosed to you from records 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 the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

COOK INLET COUNSELING

P.O. BOX 882 KENAI, ALASKA 99611

KENAI PHONE 283-3658 ♦ HOMER PHONE 235-8001

CONSENT FOR FOLLOW UP CONTACT

I, _____ give Cook Inlet Counseling and their follow-up staff permission to contact me to follow-up on my status in recovery and my general wellbeing. I understand that my participation is voluntary and that the program will follow its confidentiality policies and procedures regarding my communication with them.

I understand that any and all information in my records is protected under Federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and HIPAA 1996, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (in a covered life-threatening emergency, child abuse or neglect, threatened or actual crime at this program or against staff or appropriate court order by a judge) With this understanding, I am authorizing release of the above specified information for the purpose(s) noted below. The recipient of this information may not disclose any of it without my further written consent except as provided for by Federal regulation 42 CFR Part 2 and HIPAA.

I understand that the purpose of the contacts will be to provide support and encouragement for my status in recovery as well as research documentation. All research information is used without patient identifying information. I further understand that I can withdraw this permission at any time by writing to: Cook Inlet Counseling, P.O. Box 882, Kenai, Alaska 99611 and will expire ***after the completion of the one year follow up contact.***

The best way and time of day to reach me is:

_____
Home Phone

_____
Cell Phone

_____
Work Phone

Personal e-mail address (optional)_____

I can also be contacted by mail at this address: _____

You also have permission to contact the following person(s) in order to get information as to where I may be contacted:

1. Name: _____ Relationship:_____

   Phone: _____

2. Name: _____ Relationship:_____

   Phone: _____

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

CONSENT FOR EMERGENCY CONTACT

Date Completed: _____

Client Name: _____ Date of Birth: _____

Phone/Cell: _____ SSN: _____ Driver's License/State ID: _____

Physical Address: _____ City, State, Zip: _____

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Physical Address: _____ City, State, Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

For: In the event of an emergency.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

☐ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**
☐ Upon a specific date, event, or condition as listed here: _____
(Specific date, event, or condition)

My signature below signifies my understanding that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____	_____	_____
SIGNATURE OF CLIENT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE

Recipients:
If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

PLEASE READ BEFORE PROCEEDING

These directions are for completing the Releases of Information (ROI).
Releases of Information help facilitate your treatment.
Information may need to be exchanged with another agency(s) or person(s).

You will need ***one release per agency or person*** that may apply to you:

Example List:

- Adult Probation
- Office of Children Services (OCS)
- Alaska Safety Action Program (ASAP)
- Previous Treatment Center(s)
- Lawyer
- Medical Provider(s)
- Emergency Contact (optional)
- Parents (optional)
- Spouse (optional)
- Other

☐ **Read the form carefully and follow ALL directions exactly as they are listed to ensure that your Release of Information is valid.**

☐ **Phone numbers (and faxes if available) are very important to include on each form as they are required for telephonic exchange of information as well as information transmitted via facsimile (fax).**

☐ **The Releases of Information are NOT intended for your address or phone numbers.**

☐ **Review The Example Release of Information On The Next Page For Assistance On Completing The Form.**

☐ **Only Use Initials For Information You Want Released, An X Or a ✓ Are Not Valid On The Form.**

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611PHONE (907)283-3658 ♦ FAX (907)283-5046

CONSENT FOR RELEASE OF INFORMATION (ROI)

Name: **JANE DOE** Date of Birth: **05/05/1985**

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

To: **ALCOHOL SAFETY ACTION PROGRAM**
(*NAME OF **ORGANIZATION** AN **INDIVIDUAL**, OR **THIRD-PARTY PAYER***)

Organizations Mailing Address: **805 Frontage Rd Ste. 200B**

City: **KENAI** State: **ALASKA** Zip Code: **99611**

Phone: **907-283-3586** Fax: **907-283-4029** E-Mail: _____

Information to be disclosed: (*INITIAL ALL THAT APPLY*) INITIALS ONLY (X OR ✓ ARE NOT VALID)

JD All Listed Below; ***EXAMPLE:* ONLY INITIAL ALL LISTED BELOW**

OR: ONLY INITIAL WHAT YOU WANT TO DISCLOSE

_____ Assessment/Interpretive Summary	**JD** U/A Drug Test Results
JD Treatment Plan or Summary	**JD** Attendance
JD Treatment Review/Progress	_____ Financial/Payment Information
_____ Psychological Evaluation	_____ Other: _____
_____ Discharge/Transfer Summary	_____ Other: _____

Purpose of Disclosure: (*INITIAL ALL THAT APPLY*) INITIALS ONLY (X OR ✓ ARE NOT VALID)

_____ All Listed Below;

JD Further Treatment/Coordination of Care	_____ Financial
_____ At the Request of Client	_____ Payment & Health Care Operations
JD Legal Purposes	_____ Other: _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

☒ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**
☐ Upon a specific date, event, or condition as listed here: _____
(Specific date, event, or condition)

☐ This ROI is Revoked: _____ _____
SIGNATURE OF CLIENT DATE ROI IS REVOKED

My signature below signifies my understanding that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Jane Doe	JANE DOE	01/01/21
SIGNATURE OF CLIENT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE

Recipients:
If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

CONSENT FOR RELEASE OF INFORMATION (ROI)

Name: _____ Date of Birth: _____

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

To: _____
(*NAME OF **ORGANIZATION** AN **INDIVIDUAL**, OR **THIRD-PARTY PAYER***)

Organizations Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Information to be disclosed: (*INITIAL ALL THAT APPLY*) INITIALS ONLY

_____ All Listed Below; **OR:**

_____ Assessment/Interpretive Summary
_____ Treatment Plan or Summary
_____ Treatment Review/Progress
_____ Psychological Evaluation
_____ Discharge/Transfer Summary
_____ U/A Drug Test Results
_____ Attendance
_____ Financial/Payment Information
_____ Other: _____
_____ Other: _____

Purpose of Disclosure: (*INITIAL ALL THAT APPLY*) INITIALS ONLY

_____ All Listed Below; **OR:**

_____ Further Treatment/Coordination of Care
_____ At the Request of Client
_____ Legal Purposes
_____ Financial
_____ Payment & Health Care Operations
_____ Other: _____

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☐ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**
☐ Upon a specific date, event, or condition as listed here: _____
(Specific date, event, or condition)

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_____ _____ _____
SIGNATURE OF CLIENT PRINT NAME DATE

_____ _____ _____
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE RELATIONSHIP TO CLIENT DATE

Recipients:
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COOK INLET COUNSELING

P.O. BOX 882 KENAI, AK 99611
PHONE (907)283-3658 ♦ FAX (907)283-5046

CONSENT FOR RELEASE OF INFORMATION (ROI)

Name: _____ Date of Birth: _____

Request/Authorize information to be exchanged between:
COOK INLET COUNSELING and

To: _____
(*NAME OF **ORGANIZATION** AN **INDIVIDUAL**, OR **THIRD-PARTY PAYER***)

Organizations Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Information to be disclosed: (*INITIAL ALL THAT APPLY*) INITIALS ONLY

_____ All Listed Below; **OR:**

_____ Assessment/Interpretive Summary
_____ Treatment Plan or Summary
_____ Treatment Review/Progress
_____ Psychological Evaluation
_____ Discharge/Transfer Summary
_____ U/A Drug Test Results
_____ Attendance
_____ Financial/Payment Information
_____ Other: _____
_____ Other: _____

Purpose of Disclosure: (*INITIAL ALL THAT APPLY*) INITIALS ONLY

_____ All Listed Below; **OR:**

_____ Further Treatment/Coordination of Care
_____ At the Request of Client
_____ Legal Purposes
_____ Financial
_____ Payment & Health Care Operations
_____ Other: _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

☐ In one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**
☐ Upon a specific date, event, or condition as listed here: _____
(Specific date, event, or condition)

☐ This ROI is Revoked: _____ _____
SIGNATURE OF CLIENT DATE ROI IS REVOKED

My signature below signifies my understanding that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____ _____ _____
SIGNATURE OF CLIENT PRINT NAME DATE

_____ _____ _____
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE RELATIONSHIP TO CLIENT DATE

Recipients:
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AUDIT

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Question 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7,8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year.
(4) Yes, during the last year.

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year.
(4) Yes, during the last year.

Add up the points associated with answers. _____ A total score of 8 or more indicates harmful drinking behavior.