

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 COUNCIL ON ALCOHOL AND DRUG ABUSE 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	_____ U/A Drug Test Results
_____ Treatment Plan or Summary	_____ Attendance
_____ Treatment Review/Progress	_____ Financial/Payment Information
_____ Psychological Evaluation	_____ Other: _____
_____ Discharge/Transfer Summary	_____ Other: _____

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

_____ All Listed Below; **OR:**

_____ Further Treatment/Coordination of Care	_____ Financial
_____ At the Request of Client	_____ Payment & Health Care Operations
_____ 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.

SIGNATURE OF CLIENT PRINT NAME DATE

SIGNATURE OF PARENT, RELATIONSHIP TO CLIENT DATE
GUARDIAN OR REPRESENTATIVE

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.