* * EXAMPLE * *

COOK INLET COUNSELING

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

CONSENT FOR RELEASE OF INFORMATION (ROI) OR:

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

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

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

Organizations Mailing Address: **P.O. BOX 1410**

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

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

_____ All Listed Below;

__**JD**__ 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.

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.