

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: 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)

JD All Listed Below; EXAMPLE: INITIAL ALL LISTED BELOW

OR: ONLY INITIAL WHAT YOU WANT TO DISCLOSE

<input type="checkbox"/> Assessment/Interpretive Summary	<input type="checkbox"/> U/A Drug Test Results
<input checked="" type="checkbox"/> <u>JD</u> Treatment Plan or Summary	<input checked="" type="checkbox"/> <u>JD</u> Attendance
<input checked="" type="checkbox"/> <u>JD</u> Treatment Review/Progress	<input type="checkbox"/> Financial/Payment Information
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Discharge/Transfer Summary	<input type="checkbox"/> Other: _____

Initials
Only

Purpose of Disclosure: (INITIAL ALL THAT APPLY)

All Listed Below;

<input checked="" type="checkbox"/> <u>JD</u> Further Treatment/Coordination of Care	<input type="checkbox"/> Financial
<input type="checkbox"/> At the Request of Client	<input type="checkbox"/> Payment & Health Care Operations
<input checked="" type="checkbox"/> <u>JD</u> Legal Purposes	<input type="checkbox"/> Other: _____

Initials
Only

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.

Jane Doe JANE DOE 01/01/21
SIGNATURE OF CLIENT PRINT NAME DATE

SIGNATURE OF PARENT, RELATIONSHIP TO CLIENT DATE
GUARDIAN OR REPRESENTATIVE

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

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.