Catholic Social Services

Consent for Release of Confidential Information

Name: _____ **DOB:**_____

Address: _____
Street or PO Box City State Zip Code

Telephone: _____**Parent/Legal Guardian:** _____

I grant permission for: **Catholic Social Services 4600 Debarr Rd Suite 201 Anchorage AK 99508**
Phone: 907-222-7300 Fax: 907-258-1091

To (check all that apply):

□ Release Information to	□Obtain information from
□ Verbally	□In writing and/or electronically

Name: _____**Agency:**_____

Address: _____ **Telephone:** _____
Street or PO Box City State Zip

Regarding the following information (**CLIENT INITIAL** all that apply):

	Assessment, including diagnosis & treatment recommendations (Sub Use Only, MH Only, Integrated)		Housing Coordination
	Written/Verbal Communication		Treatment Status or progress in treatment
	Results of Urinalysis and/or alcohol breathalyzer		Discharge Date and Summary
	Attendance / Compliance		Medication Needs
	Treatment Plan		Other (please specify):

For the following purposes (**CHECK** all that apply):

	Referral/Treatment Placement follow-up		Coordination of services or care
	Provide referral information		Other (please specify):
	Verify participation in treatment		Other (please specify):

I understand that my alcohol and/or drug treatment records are protected under Federal laws governing the confidentiality of substance use disorder records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and cannot be disclosed without my written consent unless otherwise provided for by the regulations. **I also understand that I may revoke this consent orally, pursuant to 42 C.F.R. Part 2, or in writing at any time** except to the extent that action has been taken in reliance on it (any information that has already been released cannot be recalled). Treatment, payment or eligibility for services will not be contingent on completing this form, but if we are unable to get the necessary information for services, it may result in our being unable to provide those services.

This consent will expire one year from date signed or on: _____

_____I have received / declined a copy of this form.

Client or Legal Guardian Signature: _____Date: _____

Witness Signature: _____Date: _____

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___ **(Check if Substance Use Information is Included)**

To the Recipient of Confidential Information

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 further disclosure of this information unless further disclosure is expressly 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 patient.