

# CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_  
authorize the **FOLLMAN AGENCY**, 910 S. Anacortes Street, Burlington, WA 98233 to receive and/or disclose to:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone/Fax)

For the purpose of : To Enable open communication and exchange of information

I understand that my records are protected under Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 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 at any time except that action has been taken in reliance on it (e.g. probation, parole, etc) and that in any event this consent expires automatically as described:

Authorization expires after the following action takes place: 90 Days Post Discharge  
(Specification of the date, event or condition upon which this expires)

I request the following information to be release: (Client's initials required next to check mark )

- \_\_\_\_\_ Knowledge that I am a client at this agency (friends, relatives)
- \_\_\_\_\_ Diagnostic impression, symptomology, evaluation results, and recommendations
- \_\_\_\_\_ Drinking/drug use history and intake information
- \_\_\_\_\_ Copies of Court Ordered Treatment Plan and/or Probation Records
- \_\_\_\_\_ Abstinence status, progress reports, attendance records
- \_\_\_\_\_ Results of Urinalysis or Breathalyzer test(s)
- \_\_\_\_\_ Discharge Summary and Aftercare plans
- \_\_\_\_\_ Compliance with A/DIS requirements
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

The information will be released in the following form(s):

Written  Verbal  Audio  Video  Electronic (including Fax)  Other \_\_\_\_\_

**Notice: Prohibition or Re-Disclosure prohibits you from making further disclosure of information given above (42 CFR Part 2).**

I understand that generally this agency 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. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Executed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Client Signature