RIVER CAIRN COUNSELING

Substance Abuse Treatment
Release of Information

I, _____ [Client name], whose Date of Birth is _____,

authorize River Cairn Counseling to □ disclose to and/or □ obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Other_____
_____ Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date (No more than 1 year from today's date): _____ or as otherwise indicated: _____
_____

Conditions

I further understand that River Cairn Counseling will not condition my treatment on whether I give authorization for the requested disclosure, except for if the purpose of the treatment is solely to create PHI for disclosure to a third party (e.g., a fitness for duty evaluation). However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I understand that River Cairn Counseling is not responsible if the third party authorized on this form rediscloses the PHI without being permitted.

I will be given an electronic copy of this authorization for my records. If I would like a physical copy, I will provide written request to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Counselor Date