Consent to Disclose Alcohol and Drug Abuse Patient Records

Client Name: (please print): ---
Other names used in treatment, if any: ---

I authorize Western Psychological to exchange information regarding my treatment and participation in Western Psychological and Counseling Services, Inc's Chemical Dependency Program:

Name: ---

Attention: ---

Address: ----

Phone: ---

City-State, Zip: ----

Fax: ---

Initial all types of A/D information to be disclosed to above party:
Treatment related:

____ (**Initial**) To verify treatment dates/discharge status
____ (**Initial**) CD evaluation and recommendations
____ (**Initial**) Progress notes
____ (**Initial**) Attendance
____ (**Initial**) Legal information
____ (**Initial**) TB test information
____ (**Initial**) Progress in treatment/Treatment compliance
____ (**Initial**) Urinalysis information and results
____ (**Initial**) Follow up to locate me
____ (**Initial**) Progress updates
____ (**Initial**) DMV/DOL information
____ (**Initial**) Other:
(**specify**)_____

Purpose for the disclosure of the above information authorized herein is to: (Initial and write specific reason)

____ (**Initial**)(**Coordination of care)**

I understand that:

I understand that I do not need to sign this consent. If I refuse to sign this, it will not prevent me from getting drug/alcohol treatment at Western. The only exception is if the services I am seeking are only for providing health information to someone else and this consent is needed to make the disclosure.

I understand that the information used or disclosed as a result of this consent may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of drug/alcohol diagnosis, treatment, or referral information.

I understand that I may revoke my consent at any time. If I revoke my consent, the information described may no longer be used or disclosed for the reasons described here. If Western has already used or disclosed information in reliance on this consent that use or disclosure cannot be undone. To revoke this authorization, I can request the form from Western's front office or my provider. I complete the form and return it to my provider or front desk.

I have read and understand this consent:

Client Signature: _____ **Date:**_____

If personal representative, print name: _____

Relationship to client: (Please initial)

____ **(Initial) Parent**
____ **(Initial) Legal Guardian**
____ **(Initial) Power of Attorney/healthcare**

Personal Representative Signature: _____ **Date:** _____

Witness:_____ **Date:** _____

If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

Event expiration: ____(Initial)__90 days after completion of treatment_____