ALDIE COUNSELING CENTER
11 Welden Drive **2291 Cabot Boulevard West**
Doylestown, PA 18901 **Langhorne, PA 19047**
215-345-8530 215-642-3230

AUTHORIZATION TO ALLOW FOR RELEASE OF INFORMATION **FROM ALDIE**

I, _____ Ct.# _____ (D.O.B.)_____
(*Print Name*)

authorize Aldie Counseling Center **to disclose the following information** from my client record to:

_____
(*Write name of facility, organization or individual that may receive this information*)

Note to Receiving Facility/Individual: *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 any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFT 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 abuse patient.*

To a CRIMINAL JUSTICE entity or GOVERNMENT OFFICIALS for the purpose of coordination of treatment, or to a THIRD PARTY PAYER for funding purposes, INFORMATION THAT MAY BE RELEASE IS LIMITED TO ONLY THE FOLLOWING: (*check*)

- ☐ A. **Presence in treatment** - beginning date of treatment, attendance patterns, expected length of stay
- ☐ B. **Prognosis** - Diagnosis, how treatment benefits client, whether client should continue in treatment
- ☐ C. **Nature of Project** - Services offered, purpose of services, treatment methods and models
- ☐ D. **Progress** - Client's denial or lack of denial in coming to terms with addiction; cooperation with treatment plans & agency rules.
- ☐ E. **Relapse** – Client's relapse status and frequency.

For facilities, organizations or individuals other than criminal justice entities, government officials, or third party payors:

Circle appropriate numbers below for information that may be released:

1. Assessment Results (Treatment Recommendations)
2. Presence in treatment; record of attendance
3. Diagnostic summary
4. Treatment Plan and summary of treatment
5. Brief description of progress; prognosis
6. Results of Urine Screens
7. Discharge summary and Aftercare Plan
8. Psychiatric Records
9. Appointment scheduling /Transportation needs
10. Other (Specify):_____

This information will be disclosed for the purpose noted below: (***circle numbers***)

1. Coordination of treatment with other professionals
2. Report to referral source
3. Funding and monitoring to obtain insurance or other benefits
4. Coordination of services with attorneys
5. Coordination of treatment with family/concerned persons
6. Coordination of services with criminal justice
7. Other (Specify) _____

I understand that my alcohol and/or drug treatment records are protected under the 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, Pts. 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 to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **3 months after discharge**

_____
(*Write: Date, event, or condition under which this consent is to expire*)

I understand that generally, Aldie Counseling Center 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 also understand that I am entitled to receive a copy of this consent form if I want a copy of it. **Accepted**_____ **Refused**_____

_____ _____
Signature of Client Date Signature of Witness Date

Note: Do not sign this form unless all applicable information on this page is completely filled out.