

HOME ON THE RANGE AUTHORIZATION FOR RELEASE OF INFORMATION

Resident _____ Birth Date _____

**I, THE UNDERSIGNED, HEREBY AUTHORIZE HOME ON THE RANGE'S
LICENSED ADDICTION COUNSELOR
TO RELEASE INFORMATION TO, OR EXCHANGE INFORMATION WITH:**

Name of Person: _____
___ DJV ___ Social Services ___ Parent(s) ___ Other: _____
Address/City/State/Zip: _____

THE FOLLOWING INFORMATION IS REQUESTED:

<input checked="" type="checkbox"/> Assessment Summary	<input checked="" type="checkbox"/> Physical Exam Results
<input checked="" type="checkbox"/> CD Treatment Discharge Summary	<input checked="" type="checkbox"/> CD Treatment Progress Reports
<input checked="" type="checkbox"/> Previous CD Evaluations	<input checked="" type="checkbox"/> Aftercare Plan
<input checked="" type="checkbox"/> Alcohol and Drug Collateral	Other: _____
<input checked="" type="checkbox"/> Report of an Addiction Evaluation	

THE REQUESTED INFORMATION WILL BE USED FOR:

<input checked="" type="checkbox"/> Alcohol & Drug Evaluation	<input checked="" type="checkbox"/> Legal Purposes
<input checked="" type="checkbox"/> Treatment Planning	Other _____

THE INFORMATION MAY BE COMMUNICATED IN THE FOLLOWING MANNER:

<input checked="" type="checkbox"/> Verbal	<input checked="" type="checkbox"/> Written	<input checked="" type="checkbox"/> Other /Electronic _____
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THIS RELEASE OF INFORMATION REMAINS IN EFFECT UNTIL:

Date: _____

Unless I revoke this authorization prior to such time, this authorization shall not exceed **90 days** from when authorization is given for a one time release of information and not to exceed **1 year** when a release of information is required for ongoing services.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, 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. A photocopy of this release is as effective as the original.

Signature of Client

Date (release takes effect)

Signature of Parent/Guardian

Date (release takes effect)

Notice to whoever disclosure is made: 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 express permitted by the written consent of the person to whom it pertains or as otherwise 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.

Any confidential information listed above is provided by HOTR's Licensed Addiction Counselor.