Consent Form Client Name: _____

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.**

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED Presence in treatment, medical records, medication list, medication history, psychosocial, urine screen results, progress notes, diagnosis information, treatment recommendations, discharge or transfer information, demographics, and insurance information.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordination of care and/or transfer coordination

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION Facility: Address: Phone: Fax:	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION And: Name: Primary Addiction Counselor, or Designee Facility: Cayuga Addictions Recovery Services Address: 334 West State Street, PO Box 789 Ithaca, NY 14850 Phone: (607) 273-5500 Fax: (607) 273-1277

I, the undersigned, have the read the above and authorize the staff of the disclosing/ releasing facility name to disclose/ release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance on it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition would apply. I also understand that any disclosure/ release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R Pts. 160 &164; and that redisclosure of this information to be a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above: **60 days after discharge**

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program 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 have received a copy of this form, as recognized by my signature below.

_____ _____

Client Signature Date