Abbey Road Counseling Services

415 North Main Street #104 Cedar City, Utah 84721

435-586-9521 FAX (435) 586-4268

CONSENT/AUTHORIZATION FOR RELEASE OF CONFIDENTIAL ALCOHOL/DRUG TREATMENT INFORMATION

I, ______________________________________, consent/authorize Abbey Road Counseling Professionals to disclose information concerning my alcohol/drug treatment, including diagnosis, mental health/chemical dependency evaluations, urine analysis results, information about my attendance or lack of attendance at treatment sessions, cooperation with the treatment program, and prognosis to each of the following for the purpose of monitoring my treatment progress and compliance.

Criminal Justice Referrals

__Adult Probation and Parole
__Fifth District Court/Fifth District Drug Court
__Fifth District Juvenile Court
__Fifth District Juvenile Probation
__Iron County Attorney's Office
__Other____

__Iron County-Utah State Correctional Facility
__Utah Division of Child and Family Services
__Utah State Public Safety Department
__Iron County Drug Court
__Iron County Justice Court

Communications with Family and Friends

Abbey Road Counseling Professionals is **authorized to disclose information to the private individuals named below**, for the purpose of enabling such individuals to obtain information concerning my presence and progress in treatment, and so that family members may be contacted to schedule treatment activities in which they may choose to participate. Family, Friends, etc., to whom disclosure is authorized:

____

____

NOTICE: To accompany Release of Alcohol and Drug Abuse Records

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any us of the information to criminally investigate or prosecute any alcohol and drug abuse patients.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. Abbey Road Counseling Professionals cannot guarantee this person/agency will not re-disclose your records. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that my alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part2) and the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Parts 160 and 164).

I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation. I understand revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 90 days after my client services are terminated.

Signature(s):

Client Signature ____ **Date** ____________________
If Minor, Authorized Representative __________________________________ Date ____________________
Printed Name of Authorized Representative ___________________________ Relationship ______________
Authorized Representative Phone Number ____________________________
Staff Member/Witness Signature _________________________________ Date ____________________