WASHINGTON DRUG AND ALCOHOL COMMISSION, INC.

PROVIDERS, FAMILY/CONCERNED OTHERS

CONSENT TO **RELEASE** CONFIDENTIAL INFORMATION

I_____(D.O.B.) _____give my consent to Washington Drug and Alcohol Commission Case Management to release to _____ and **Emergency Contact** the following from my client record for the sole purpose of:

- ☒ Completion of the Intervention Program
- ☒ Coordinating case management efforts with Adult Probation
- ☒ Coordination of services

The information will be disclosed for the purpose noted above and that information will be limited to the following items:

PROBATION ONLY

☒ Client attendance information including completion status

☒ Client identifying information (Name, address, social security)

☒ Client participation and appropriateness

☒ Whether the client is in compliance with the program rules

☒ Client prognosis

☒ Report of relapses into drug and alcohol abuse and frequency of any such relapses

☐ Other **(specify)**_____

FAMILY/CONCERNED OTHER ONLY

☐ Recommendations

☐ Prognosis

☐ Description of client's progress in intervention program

☒ Emergency contact: _____

☐ Other **(specify)**_____

This form has been explained to me and by signing it, I am verifying my understanding that:

- My records are protected under the state and federal regulations. I understand that the above information has been disclosed from records whose confidentiality is protected by the federal confidentiality of substance abuse patient records statute, section 543 of the Public Health Service Act, 42 U.S.C. 290dd-2, and its implementing regulation, 42 C.F R.R., part 2; the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations; and, the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S.§1690.1010 et.seq.

Federal Regulations (42 CFR, Part 2) prohibits any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I understand that I may revoke this consent at any time by notifying this agency, verbally or in writing, except to the extent that action has been taken in reliance on my consent.

I have been offered a copy of this form and I have ☐ Accepted ☒ Refused

This consent will expire on _____(only for as long as necessary to accomplish the purpose of the release and never more than one year.)

_____ _____

Signature of Client Date

_____ _____

Signature of Witness Date

I, _____have revoked this consent on _____(date)