



Patient Name

Patient Number

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, DOB: _____, SSN: _____,

authorize Tri-State Treatment to disclose/to exchange with

_____ the following information:

(Name of the person or organization to whom disclosure/exchange is being made)

INFORMATION TO BE RELEASED (as limited as possible):

Participation in Tx	Diagnosis	Tests Completed/Results	History & Physical
Discharge Summary	Physician's Orders	Time in Treatment	Treatment Plan
Assessments	Current Dose Amt.	Current Phase Level	Lab Work
Drug Screen History	Discharge Date	PPD	Other: _____

OR, select from the list below:

Coordination of Care: Identifying information, participation in treatment, medications prescribed, needs for continuing treatment, appointments attended/scheduled, recommendations, concerns, prognosis

Pregnant: Identifying information, participation in treatment, medical concerns, take home schedule, prescriptions, appointments/schedule, specialized tests, estimated date of conception, estimated due date, delivery outcome, prognosis and/or complications.

Guest Dose/Transfer: Identifying information, participation in treatment, medical issues, take home schedule.

Family Involvement: Participation in treatment, information relative to session content if attendance.

Dual Enrollment: Identifying information, including picture ID, participation in treatment, medications prescribed, appointment(s) attended/scheduled.

PURPOSE of Disclosure (as specific as possible):

I understand that my records are protected under the 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. Federal regulations also prohibit any further re-disclosure of this information by the person or organization with which you have consented for us to disclose/exchange information. I hereby release Tri-State Treatment and any associated staff from all liability or legal responsibilities that may arise from the release of such records. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

This Release of Information is valid until the completion of my treatment at this facility, unless otherwise revoked in writing.

Patient Signature: _____ Date: _____

Please fax back to 423-428-0046



I, _____, revoke my consent. Date: _____