



3019 County Complex Drive
Canandaigua, NY
14424

Telephone: 585-396-4190
Fax: 585-393-2916

CONSENT TO RELEASE OF INFORMATION

I, _____, do hereby consent to and authorize
(Client Name)

_____ to, as indicated below, *release to* and *obtain from*,

(Name of organization, program, professional, parent or person)

THE FOLLOWING INFORMATION PERTAINING TO MYSELF TO BE DISCLOSED: (client initial boxes checked)

OBTAIN RELEASE

- Presence in treatment/service (including admission & discharge dates).
- Medical history and physical exam.
- Biopsychosocial evaluation summary.
- Educational records.
- Psychological tests of projective assessments.
- Diagnosis, brief description of progress and prognosis.
- Recommendations.
- Treatment/service plans.
- Result of drug screens.
- Discharge summary, continuing care plans.
- Other: _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES: (client initial boxes checked)

- To complete an evaluation.
- To provide ongoing treatment/service/continuing care.
- To coordinate treatment/service efforts with my family/significant others/concerned persons.
- To coordinate treatment/service with other treatment/service providers.
- To make recommendations to the Department of Motor Vehicles.
- To make recommendations to the Department of Social Services.
- To coordinate treatment/services with school staff and make recommendations.
- Other: _____

I understand that my alcohol and /or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(state specific date, event or condition upon which release will expire)

I understand that generally Ontario County Substance Abuse Services (Turnings) 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.

Signature of Participant **Date**

Signature of Parent/Guardian (If required) Date

TURNINGS

Instructions for completing the "Consent to Release of Information"

Every part of this release must be filled in for the release to be valid.

1. Print the client name.
2. Print "Turnings".
3. Print the name of the individual/agency to whom we are releasing material and/or obtaining material.
4. Check the appropriate items to be released or obtained. "Presence in treatment/service" is always checked under release, as the very act of sending the release makes it known that the client has been here. Use other for any item not included in the list. Have the client initial each checked item to insure that items are not checked after the client has signed.
5. Check the appropriate box (or use other) explaining the purpose for the release, and have client initial.
6. Put in the date (usually one year from the date signed) or the event (end of treatment, etc.) upon which the release will automatically expire.
7. Have the client sign and date the release. Client signature is required in all cases, no matter how young the client.
8. For clients under 18 signature of a parent or guardian is also required.