



CONSENT FOR DISCLOSURE OF SUBSTANCE ABUSE TREATMENT INFORMATION

I, _____ DOB: _____ request/authorize
 Jett Morgan Treatment Services, LLC

_____ Disclose information to: **and/or** _____ Obtain information from:
 (Nature and amount of information to be disclosed; as limited as possible)

Name: _____
 Address: _____
 Phone: _____

Initial all alcohol/drug treatment records that apply:

- | | |
|--|----------------------------------|
| _____ Presence In Treatment | _____ UA Results |
| _____ Attendance | _____ Discharge Summary |
| _____ Assessment/Interpretive Summary /Recommendations | _____ Appointment Information |
| _____ Treatment Plan/Case Reviews | _____ Leave message for client |
| _____ Collateral Legal Information and History | _____ Financial/Billing/Payments |

For the purpose(s) of:

- | | |
|----------------------------|-------------------|
| _____ Further Treatment | _____ Personal |
| _____ Legal Request | _____ Other _____ |
| _____ Coordination of Care | _____ |

Disclosure is to be: verbally, in writing and /or electronic

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 and 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 reliance in reliance on it, and that in any event this consent expires automatically as follows: _____ 90 days after discharge, or _____ other terms: _____
 _____ (specification of the date, event or conditions upon which this consent expires) IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE ONE YEAR FROM DATE SIGNED.

I understand that generally Jett Morgan Treatment Services, LLC 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.

By my signature below I indicate that I have read this document, or have had it read to me, that I fully understand its meaning, that I consent to its terms knowingly and voluntarily, that I have not been under any undue duress or influence nor under the influence of alcohol or drugs in making this agreement.

Signature: _____ **Date:** _____
 Client

Signature: _____ **Date:** _____
 Parent, guardian or person authorized to sign for client

Signature: _____ **Date:** _____
 Witness

This notice accompanies a discloser of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.