CAPITAL RECOVERY CENTER

MEMBER CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Member Name	***Authorized Individual/Agency/Facility***
_____ **Birthdate** _____ I hereby authorize representatives of Capital Recovery Center to: ******Please Initial****** ____ Request info from noted Agency/Individual ____ Exchange Information w/ noted Agency/Individual ____ Disclose to noted Agency/Individual	_____ Name _____ Address _____ City/State/Zip

The following information from medical or mental health records:

******Please Initial Each Section as it Applies to this Consent******

_____ Hospital Admit/Discharge Information
_____ Medical Records/Medications
_____ Mental Health Intake/Treatment Summaries
_____ Crisis/Safety Plan
_____ Psychiatric Evaluation Records
_____ Probation/Parole Reports
_____ Phone Contact (describe below)
_____ Mental Health Progress Notes/Reports
_____ Other (describe below)
_____

SPECIFIC AUTHORIZATIONS

_____ Admit/Discharge Reports _____ Intake/Treatment Reports _____ Progress Notes/Reports _____ Other (describe below) _____	**Drug/Alcohol** I understand that my records may contain information regarding diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for these records to be released *(Per 42CFR2)*.
_____ Admit/Discharge Reports _____ Intake/Treatment Reports _____ Progress Notes/Reports _____ Other (describe below) _____	**AIDS/HIV/STD** I understand that my records may contain information regarding testing, diagnosis or treatment of HIV/AIDS or sexually transmitted diseases. I give my specific authorization for these records to be released *(Per RCW 70.24.105)*.

Disclosure of this authorized information is required for the following purpose(s): **Coordinate Care**

All member information is confidential and disclosure to any other person or organization is prohibited without specific written consent or as otherwise specified by law. I understand that I may revoke this authority at any time, except to the extent that action has already been taken. To revoke this authorization, the request must be in writing to Capital Recovery Center. Capital Recovery Center is prohibited from conditioning continuation of services on my agreement to sign this authorization. A copy or facsimile shall be considered valid in lieu of the original authorization.

_____ _____
Member Signature Date of Signature

_____ _____
Witness or Legal Representative Signature Date of Signature

Unless revoked in writing by myself, this authorization will expire 90 days after Discharge from CRC.
(Per RCW 70.02.040)