CAPITAL RECOVERY CENTER

Member Consent for Release of Confidential Information

Member Name

_____

Birth Date

_____

I hereby authorize representatives of Capital Recovery Center to: ***(Please initial below)***

_____ Request info from noted Agency/Individual

_____ Exchange info with noted Agency/Individual

_____ Disclose to noted Agency/Individual

Authorized Individual/Agency/Facility:

Name

_____

Address

_____

City/State/ZIP

_____

Phone

_____

Fax

_____

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

Drugs and 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 & STDs

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)*

_____ Admit/Discharge Reports
_____ Intake/Treatment Reports
_____ Progress Notes/Reports
_____ Other (describe below)
_____
_____

Disclosure of this authorized information is required for the following purpose(s): **Coordination of 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 authorization 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 (CRC). CRC 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)