



*Integrative Counseling &
Trauma Recovery Center*

Authorization for Release Substance Abuse Treatment Information

I, _____, whose Date of Birth is _____,

authorize Integrative Counseling and Trauma Recovery Center to disclose to and/or obtain from:

[Insert Name of Person or Title of Person or Organization]
the following information:

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

- | | |
|---|--|
| _____ Assessment | |
| _____ Diagnosis | _____ Toxicological Reports/Drug Screens |
| _____ Psychosocial Evaluation | _____ Educational Information |
| _____ Psychological Evaluation | _____ Discharge/Transfer Summary |
| _____ Psychiatric Evaluation | _____ Continuing Care Plan |
| _____ Treatment Plan or Summary | _____ Progress in Treatment |
| _____ Current Treatment Update | _____ Demographic Information |
| _____ Medication Management | _____ Other _____ |
| _____ Information | |
| _____ Presence/Participation in Treatment | _____ Other _____ |
| _____ Nursing/Medical Information | _____ |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than marketing, sale of information, research or as specified above, please specify:

Research

- If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and the individual's ability to opt into each study.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Kristin Free at Integrative Counseling and Trauma Recovery Center, 48 Hanover Ln Ste. #2, Chico, CA 95973. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date:

Conditions

I further understand that Integrative Counseling and Trauma Recovery Center will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

Signature of Patient/Client

Date

Signature of Parent, Guardian or Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).