

**RESIDENT SERVICE COORDINATOR  
CONSENT TO RELEASE OF INFORMATION**

Resident Name (First, Middle, Maiden, Last): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am presently a resident at: \_\_\_\_\_  
(NAME OF FACILITY)

I authorize the Service Coordinator (SC) at this "Facility to disclose and obtain the following information:

\_\_\_\_\_

To the following person or organization: \_\_\_\_\_

\_\_\_\_\_

The purpose of this disclosure is to:

\_\_\_\_\_

\_\_\_\_\_

Information obtained by the service coordinator will be maintained as confidential and released only to those employees who have a need to know such information, as required by law, or as provided in this Release. The service coordinator shall adhere to all applicable laws, regulations or professional license requirements.

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I understand that I may revoke this Consent to Release of Information at any time by providing written or verbal notice of the revocation to the Service Coordinator. This revocation will not apply to information that has been previously released or action that has been taken in accordance with, and in reliance upon, this consent.

This consent (unless expressly revoked earlier) expires one hundred eighty days from the date indicated below.

Health information disclosed pursuant to this consent may be subject to redisclosure and would no longer be protected by 45 CFR Parts 160 and 164 unless applicable state law prohibits redisclosure of the information. Federal law prohibits redisclosure of substance abuse treatment information to any person without the written authorization in accordance with 42 CFR Part 2.

Signature of Resident: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian, if applicable: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Resident: \_\_\_\_\_

Signature of SC : \_\_\_\_\_ Date: \_\_\_\_\_