

SERVICE COORDINATOR

CONSENT TO RELEASE INFORMATION

Resident Name (Last, First, Middle/Maiden): _____

Social Security Number: _____ Date of Birth: _____

I am presently a resident at: _____
(Name of Facility)

I authorize the Service Coordinator at this facility to disclose the following information:

To the following person or organization: _____

The purpose of the 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.

I understand that I may revoke this consent at any time by providing written or verbal notice 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 written authorization in accordance with 42 CFR Part 2.

Signature of Resident: _____ Date: _____

Signature of Guardian, if applicable: _____ Date: _____

Relationship to Resident: _____

Signature of Service Coordinator _____ Date: _____