Recovery & Prevention Resources of Delaware and Morrow Counties, Inc.
Authorization to Disclose Client Information: Criminal Justice System Referral

I, ____ (SS# ______-______-_______) authorize/request:

Recovery & Prevention Resources of Delaware and Morrow Counties, Inc.

118 Stover Drive Delaware, Ohio 43015-8601 Phone: (740) 369-6811 Fax: (740) 363-8742	950 Meadow Drive Suite C Mt. Gilead, Ohio 43338-1055 Phone: (419) 947-4055 Fax: (419) 947-4285

To exchange information with:

Name of Organization ____

Address ____

City, State Zip ____

Phone ______________________ Fax ________________________

Type of information to be disclosed: Diagnostic assessment, attendance information, treatment recommendations and/or progress, prognosis, drug testing results, discharge summary.

Amount of information to be disclosed:

___Information pertaining to the current treatment admission at Recovery & Prevention Resources

___ Information pertaining to all treatment admissions at Recovery & Prevention Resources

___ (other – specify)_______________________________________

The purpose or need for such disclosure is: to coordinate effective delivery of treatment services.

I understand that this authorization to disclose confidential information will remain until the later of either (a) a formal and effective termination or revocation of my probation, parole, or other proceeding under which I was mandated into treatment or (b) 90 days after my discharge from treatment at Recovery & Prevention Resources.

This authorization to disclose confidential information cannot be revoked by me until there has been a formal and effective termination or revocation of my probation, parole, or other proceeding under which I was mandated into treatment.

I further understand that generally, Recovery & Prevention Resources may not condition my treatment on whether I sign a form authorizing disclosure of information, but in certain limited circumstances I may be denied treatment if I do not sign such authorization.

I understand that my alcohol/drug treatment records are protected under Federal Confidentiality Rules, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise permitted by the federal rules. A general authorization for the release of medical or other information is NOT sufficient for this purpose. I also understand that recipients of this information may re-disclose it only in connection with their official duties.

Signature of Client ____ Date ____________________________

Signature of Witness ____ Date ____________________________

Signature of Parent/Guardian if Client is a minor ____