ARCA

Addiction Recovery Care Association

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

DATE OF BIRTH: _____ NAME: _____

RECORD #: _____

I, the above named, hereby authorize:

Name of Organization: **Addiction Recovery Care Association (ARCA**)_____

Address: **1931 Union Cross Road Winston-Salem NC 27107**_____

To disclose to, receive from and communicate with:

Agency/Individual: _____Phone No: _____
(Name of Person/Agency to which disclosure is made) Fax No: _____
Address: _____

The following protected substance abuse treatment information:

_____ Name	_____ Assessment	_____ Attendance & Progress
_____ Demographics	_____ Duration of Service	_____ Admission/Discharge Verification
(age, address, phone, SS#)	_____ Treatment Plan	_____ Certificate of Completion
_____ Medical/Health History	_____ Service Order	_____ Legal History
_____ TB Test/Results	_____ Urinalysis	_____ Transition Plan
_____ Medications	_____ Diagnosis	_____ Reason for Referral

_____ Other_____

The purpose of releasing this information will be specifically:

_____ Continuation of Care	_____ Verification of admission/Discharge
_____ Referral to another SA facility	_____ Emergency Medical Information

_____ Other: _____

THE RECIPROCAL EXCHANGE OF INFORMATION IS PERMITTED WITH THIS RELEASE

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-close such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol; abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

This consent will expire one year from the date of this signature unless otherwise stipulated here: _____

_____ _____
Signature of Client Date

_____ _____
Witness Date

_____
Signature of Legal Representative (when required)