CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL AND DRUG INFORMATION

I, _____, DOB,_____, authorize
(Name of Client) (Date of Birth)

_____and
(Current Provider)

Macomb County Community Mental Health Access Center, and
(Access Management System)

Macomb County Community Mental Health Office of Substance Abuse (MCOSA),
(Funding Agency)

to communicate with and disclose to one another the following information:
My name and other personal identifying information, including social security number; my status as a client at any of the agencies listed above; initial and subsequent evaluations of my service needs; alcohol/drug and mental health diagnosis, if any; recommendations and rational for referral(s); summary of treatment progress and compliance; appointments scheduled and attendance; discharge plan and discharge status; service authorization information, other:_____.

The purpose of the disclosures authorized in this consent is, per my request, to: **provide these agencies with the information needed to: determine my readiness and/or ability to participate in treatment, arrange/authorize appropriate treatment to meet my needs, and process funding eligibility and billing/payment for services.**

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C. F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **twelve months from date signed.**

I understand that the program may not condition treatment on whether I sign this authorization, unless otherwise allowed by law. I am entitled to receive a copy of this authorization after it is signed.

Dated:_____ _____
Signature of Client

_____
Signature of Parent, guardian or authorized representative when required

Consent for Follow-Up

To ensure all clients receive appropriate services, Access Center contacts all clients who receive referral and/or authorization for treatment services. To assist in this process, **please initial <u>one</u> of the following**:

_____ I agree to be contacted by Access Center following my screening and/or after my discharge from treatment. I understand that the information I provide at follow-up is confidential and my identity will be protected. I further understand that the follow-up questions will ask for personal information, including any use of alcohol and other drugs. I understand that I may revoke my consent for follow-up by contacting the Access Management System at any time except to the extent action has been taken in reliance on it. This consent expires one (1) year after termination of my treatment or one year from notice of my failure to enter treatment, whichever comes first.

- or -

_____ I do not want to be contacted by the Access Center for follow-up services.

Signature _____ Dated: _____

A photocopy/facsimile of the signed consent shall have the same force and effect as the client's original signature.

FAX TO THE MACOMB COUNTY ACCESS CENTER AT 586-948-0223

9/14 AMS Release