## CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL AND DRUG OR MENTAL HEALTH INFORMATION

ADDICTION TREATMENT SERVICES and    Name:		Printed Name)		(Date of Birth)	(Social sec	urity number)
Name:  Agency: RECORDS DEPOSITION SERVICE, INC.  Address: PO BOX 5054  City, State, Zip: SOUTHFIELD, MI 48086-5054  Phone/Fax: P: 248.357.3330 F: 248.357.3337  Status and progress in treatment  Admission Letter  Discherge information Initial/updated assessments  Treatment Plans  Early Recovery Plans  Psychological and/or psychiatric evaluations and treatment  History and physical  Nursing assessments  The purpose of disclosures authorized in this consent is to aid in treatment and discharge planning and maintain proper mental health and medical treatment.  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 CFR Part 2, and the Health insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR 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 in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:  One year from date signed  I understand that generally Addiction Treatment Services may not condition my treatment on whether I sign a consent form, but, that in certain limited circumstances I may be denied treatment if I do not sign a consent form.  Signature of Client  Date	Lauthorize comm	unication of the	following informa	ation via verbal, written	and electronic betwe	een
Address: PO BOX 5054  City, State, Zip: SOUTHFIELD, MI 48086-5054  Phone/Fax: P: 248.357.3330 F: 248.357.3337  Status and progress in treatment Admission Letter Discherge information initial/Updated assessments Treatment Plans Early Recovery Plans Psychological and/or psychiatric evaluations and treatment History and physical Nursing assessments Needlocation Reviews The purpose of disclosures authorized in this consent is to aid in treatment and discharge planning and maintain proper mental health and medical treatment.  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 CFR Part 2, and the Health insurance Portability and Accountability Act of 1996 (HIPAA); 45 CFR Pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations already been taken in reliance on it, and that in any event this consent expires automatically as follows:  The one year from date signed Understand that generally Addiction Treatment Services may not condition my treatment on whether i sign a consent form, but, that in certain limited circumstances I may be denied treatment if I do not sign a consent form, but, that in certain limited circumstances I may be denied treatment if I do not sign a consent form.  Signature of Client			-			
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