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

______________________________ ______________ ______________
(Printed Name) (Date of Birth) (Social security number)

I authorize communication of the following information via verbal, written and electronic between
ADDICTION TREATMENT SERVICES and

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
- Discharge information
- Initial/Updated assessments
- Treatment Plans
- Early Recovery Plans
- Psychological and/or psychiatric evaluations and treatment
- History and physical
- Nursing assessments
- Medication 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.

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

______________________________ ______________
Signature of parent, guardian or authorized Representative (only when required) Date