

Starting Point, Inc.

WAC 246-341

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

I, _____, hereby authorize
(Name of client/patient)

Starting Point, Inc.

(Name of Program Exchanging/Releasing Information)

To release and/or exchange information with:

(Name of Person/Entity to which disclosure is to be made to and/or information is to be received from)

The following information: **MUST INITIAL EACH ITEM**

_____ Identifying Information	_____ Financial Compliance
_____ Psychological Testing Information	_____ Treatment Compliance
_____ Significant Other Questionnaire	_____ Social History
_____ Family Program	_____ Discharge Summary
_____ Diagnosis/Test Results/Recommendations	_____ Medical History and Physical
_____ Aftercare Plan/Participation	_____ Consultations
_____ Treatment Plan _____ Progress Notes	
_____ Urine Analysis Testing	_____ Insurance Information
_____ Deferred Prosecution Treatment Acceptance Letter	
_____ Other (specify) _____	

Method of Disclosure: { } Mail { } Phone { } Fax { } Hand Deliver
{ } Email { } Other (specify) _____

The purpose for disclosure/exchange of this information is to facilitate treatment, summarize treatment, coordinate Aftercare programs, and allow for processing of insurance (if appropriate).

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 (AHIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for the regulations. I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create assessment or report for disclosure to the recipient identified in this authorization. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires as follows:

90 days following the last date of service, or: _____
Specific date, event, or condition which this consent expires.

Signature of Client/Patient

Date

Signature of Person Authorized to Sign in Lieu of the Client (where required)

Date

Signature of Program Representative

Date