



AUTHORIZATION FOR SUBSTANCE ABUSE TREATMENT

I, _____ (Name of Authorizing Person), for _____
_____, (Client Name) with client DOB _____, authorize:

111 Windel Drive, Suite 213
Raleigh, NC 27609

Tel: 919/807-1454
Fax: 714/276-6999
email: CFLcounseling@gmail.com

to disclose to and/or obtain from: _____ (Name
of Person or Title of Person or Organization) the following information:

Description of Information to be Disclosed (Client should initial each item to be disclosed)

_____ Assessment
_____ Psychosocial Information/Evaluation
_____ Current Treatment Update
_____ Medication Management Information
_____ Educational Information
_____ Presence/Participation in Treatment
_____ Other _____
_____ Other _____

_____ Diagnosis
_____ Treatment Plan or Summary
_____ Demographic Information
_____ Progress in Treatment
_____ Continuing Care Plan
_____ Discharge/Transfer Summary
_____ Substance Use

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to *Change for Living Counseling PLLC*. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated:

Conditions

I further understand that *change for Living Counseling PLLC* will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:_____

(Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided).

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization.

Printed Name of Staff Witness

Signature of Staff Witness Date