All for Recovery, Inc
Authorization for Release of Confidential Information

I, _____, Social Security Number: _____, born on _____
authorize All for Recovery to:

____ Disclose to	____ Obtain from
____ Electronic ____ Oral	____ Written

Name of Person/Agency: _____

Address: _____
City State Zip Code

Applicant Contact Information:

Home Phone: _____

Cell Phone: _____

Email Address: _____

Relationship to Applicant: _____

The following information:

____ Presence in Treatment	____ Medical History/Current Status	____ Aftercare Recommendations
____ Progress in Treatment	____ Biopsychosocial Assessment	____ Discharge Planning
____ Treatment Plans	____ Laboratory Test Results	____ Discharge Summary
____ Psychological Assessment	____ Employment Information	____ Psychiatric History and Assessment
____ Legal Status	____ Results of Physical Exam	____ Family Information
____ Other		

For the purpose of:

____ Continuity of Treatment – Patient History – Case Management Services
____ Emergency Contact – General Updates
____ Court Services – Legal Process – Probation – Disability Claiming – Unemployment Claiming – Employment Continuity
____ Other

I understand that my records are protected under Federal regulations, (42CFR, Part2), and the Health Insurance Portability Accountability Act (HIPAA), 45 C.F.R., 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 upon written notice, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically one year from the date signed, otherwise unless specified below. I understand that generally All for Recovery may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances support or collateral investigation is a key component and we may not be able to meet your needs without the key contacts involvement. I understand I am entitled to a copy of this document in its complete form.

This authorization is valid (if not previously revoked) this consent will terminate upon 365 days from the date of signature of this form, or the following event/condition: _____, or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

Prohibition on Re-disclosure

This information has been disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.