CONSENT FOR RELEASE OF INFORMATION

Client Name: _____ Date of Authorization: _____

Birth Date: _____ Date of Expiration*: _____
*If left blank, release will expire 90 days after initial request or as otherwise noted

I, _____ ____ **when initialed, this release is reciprocal**
Authorize:

_____ Co-Occurring Disorders Institute (DBA Compassionate Directions)
Name Name

_____ PO Box 1907
Address Address

_____ Palmer, AK 99645

(907) 745-2634 (907) 745-4897

Phone Fax Phone Fax

To release the following information to CODI, Inc. (**Client please INITIAL**):

	Discharge Summary		School History/Education Plan		Progress Notes—Doctors
	Intake Summary		Social History		Progress Notes—Clinician
	Lab/X-Ray Information		Social Security/SSI		Progress Notes—Family Support
	Physical/Medical Exam		Treatment Plan		Progress Notes—Activity Therapy
	Psychiatric Examination		Verbal Exchange of Information		Progress Notes—Day Treatment
	Psychological Testing		Vocational Evaluation/Progress Notes		Progress Notes—Residential
	Client Status Review (CSR)		Alaska Screening Tool (AST)		ACE Score

I understand that the following information to be released may include information regarding the following (**Client, please INITIAL**)

	Psychiatric Treatment		Drug/alcohol abuse, treatment, rehabilitation (Signature of minor required by law)

This information is for the purpose of:

	Further Treatment		Insurance		Coordination of Care		Specific reporting of data to the State of Alaska
	Disability Claim		Legal Request		Personal		Department of Behavioral Health

The information to be released by the above-named person or organization under this agreement will not be given to any other person or organizations without my written authorization.

I understand I may revoke this authorization at any time except for that action which has already been taken to comply with it. Without my express revocation, this consent will expire on satisfaction of the need for disclosure, or 90 days from date of request. I agree to hold harmless all parties in the event or errors in transferal of information including, but not limited to, mail, facsimile, and verbal communication. I understand that I have a right to receive a copy of this request. I understand the terms of this agreement (they have been explained to me) and I give my permission:

Signature of Client: _____ Date: _____

Printed Name of Client: _____

Signature of Parent: _____ Date: _____

Printed Name of Parent: _____

Signature of Parent: _____ Date: _____

Printed Name of Parent: _____

Signature of Guardian: _____ Date: _____

Printed Name and Agency of Guardian: _____

Signature of CODI Witness: _____ Date: _____

PROHIBITION OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROHIBITED BY FEDERAL LAW, FEDERAL REGULATIONS (42CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT FOR THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISIONS OF THIS LAW SHALL BE FINED NOT MORE THAN $5,000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.

Revised 07/19/2018

Revocation

Date Auth CODI Authorization Revoked: _____

Initials of CODI Privacy Official:_____