# GENESIS RECOVERY SERVICES, INC.

## CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

THIS NOTICE DESCRIBES HOW INFORMATION PERTAINING TO YOUR TREATMENT AND LOCATION MAY BE USED AND DISCLOSED AFTER YOU HAVE BEEN DISCHARGED FROM GENESIS.

I, understand that generally Genesis may not condition my treatment on whether I sign this consent form; but in certain limited circumstances I may be denied treatment if I do not sign this consent form.

CLIENTS NAME:_____DATE OF AUTHORIZATION:_____

SSN:_____ BIRTH DATE:_____

I, _____, authorize GENESIS RECOVERY SERVICES to exchange/release information verbally, in writing, or electronically with:

Name of Person/Organization: Division of Public Assistance

Relationship: Medicaid Provider Phone: 907-269-6599

Address: 3901 Old Seward Highway, Anchorage, AK. 99503

The purpose of and need for this release is to exchange information regarding my medical records (specifically a physical exam and TB test), collateral information / current charges / criminal history, diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, D/C disposition, and (please be specific):

Release of information about eligibility for Medicaid and billing purposes.

**Any information will not be released by the above name person or organization to any other persons or organizations unless I so authorize or a court orders such release. I understand that I may revoke this authorization at any time. No further information will be released after the date of revocation. Without my express revocation, this consent will expire "upon discharge from treatment" or as follows:**

_____

Signature of Client:_____ Date:_____

Printed name of Client:_____

Signature of Witness: _____ Date:_____