

GENESIS RECOVERY SERVICES

2825 W. 42ND Avenue, Anchorage, AK 99517 • Ph: (907) 243-5130 • Fax: (907) 248-8350

CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION:

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

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 THE CONSENT FORM.

Client’s Name: _____ Date of Authorization: _____

SSN: _____ Date of Birth: _____

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

Name of Person or Organization: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Please initial beside the information you are authorizing us to release:

- | | |
|---|---|
| <input type="checkbox"/> Evaluation and Diagnosis Information | <input type="checkbox"/> Treatment Progress Notes |
| <input type="checkbox"/> Biopsychosocial Information | <input type="checkbox"/> Attendance |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Treatment Status | |
| <input type="checkbox"/> Other (please specify) _____ | |

The purpose of this release is to (please be specific): _____

Any information will not be released by the above named 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: _____

I understand that I have a right to receive a copy of this release.

_____ Signature of Patient	_____ Date	_____ Signature of Witness	_____ Date
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*Prohibition on Re-disclosure of Information: This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment made to you with the consent of such client from records protected by State and Federal Regulations. Alaska State Regulations 37.210.15(a), “Uniform Alcoholism and Intoxication Treatment Act,” states that the registration and other records of treatment facilities shall remain confidential. Federal Regulations 42 CFR Part 2, and HIPAA, 45 CFR pts 160 & 164, prohibit 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, and HIPAA, 45 CFR pts 160 164. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal Regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Rev. 11/2016*